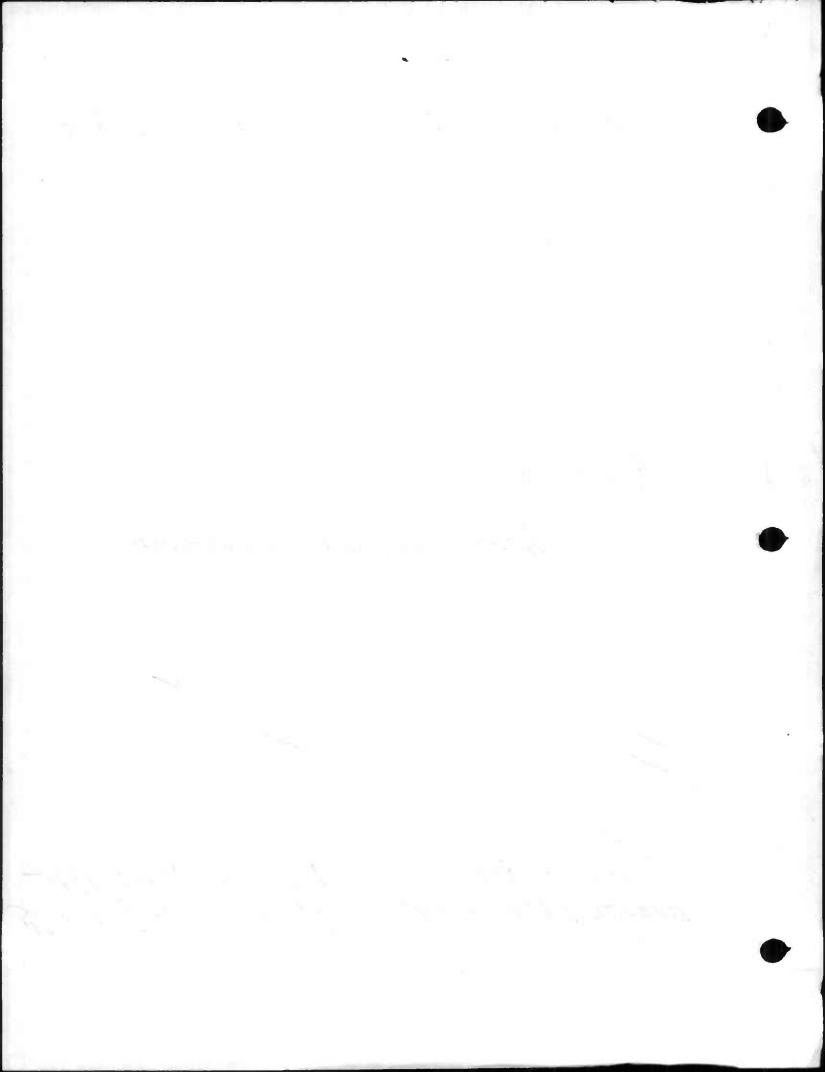
BALLIMORE, MARYLAND	nours after death. Page 6 may be retained by the hosp	ed in by the funeral director, page 5 should be detached or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Deut, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND ME	NTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lat	Loroy (NMN) Marshall May 6,7995 YEAR 8						3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 217-30-0828 9a. FACILITY NAME (If not institution, give	1½ M 2 □ F 60	M 2 F 60 YRS. MONTHS DAYS HOURS		HOURS MIN.		34 Mai	ryland		
TOR	15815 Bald Eagle	9	Brandy	wine		Prince George's				
DIRECTOR	Maryland Prin	nce George's		ndywine			10d. INSIDE CITY LIMITS? 1 YES 2 YO			
FUNERAL	15815 Bald Eagle	e Road	101. ZIP CODE 10g. 20613				-	CITIZEN OF WHAT COUNTRY? USA		
B	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 Y YES IF YES, GIVE WAR OR DA	2 NO		cify Cuban, Mexican, Pr	ORIGIN? (Specify Yes or Fuerto Ricen, etc.)	Spec	E — American Indian, k, White, etc.		
COMPLETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12)	DUCATION ade completed) College (1-4 or 5+)	life. Do NOT use r	k done during mos etired.)	of working Operator	Constru				
BE COM	17. FATHER'S NAME (First, Middle, Last) Walter Marshall		1		18. MOTHER'S NAME (First, Middle, Meiden Surm e Mae Bab		5		
5	19a. INFORMANT'S NAME (Type/Print) Nina B. Marshall		33 Hu	nting I	ane, Wald	Number, City or Town, St orf, MD 20				
	206. METHOD OF DISPOSITION 1 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of cemeter), crematory or other place) 207. SIGNATURE OF FUNERAL SERVICE LIBENSEE Mary Land 208. PLACE AND DATE OF DISPOSITION (Name of cemeter), crematory or other place) Mary Land 21. SIGNATURE OF FUNERAL SERVICE LIBENSEE Mark G. Brohawn M00053 DATE 206. LOCATION — City or Yown, State 5-10 Cheltenham, MD 21. NAME AND ADDRESS OF FACILITY Huntt Funeral Home Mark G. Brohawn M00053									
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL CER	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2						77	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINET 1/2/ TES 2 NO	HOSPITAL:	6. PLACE OF DEATH	(Check only one)						
ву рнуз	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1 inpetient 2 ER/Outpe 28a. DATE OF INJURY (Month, Day, Year)	26b. TIME C	OF 26c, INJU Y WOF	FRY AT 280 IK?	Other (Specify) 1. DESCRIBE HOW INJUF	RY OCCURED			
	3 Suicide 8 Could not b	25a, PLACE OF INJURY	At home, farm, stre	et, tactory, offica	281	LOCATION (Street and A City or Town, State)	lumber or Rural F	loute Number,		
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHY	/SICIAN: To the beat of my knowle NER: On the basis of examination	edga, death occurred a and/or investigation, i	nt the time, data of the my opinion, de	and place, and due to the	ne cause(a) and manner , data and place, and du	as stated. e to the cause(a) and manner as stated.		
TO BE (29b. SIGNATURE AND TITLE OF CERTIF	HO COMPLETED CAUSE OF DEA	um	(1)	20c. LICENSE NUMBER	30 /	1046	(Month, Day, Year)		
	AUBUSTO F.	TO OFFIG HOS	TURE O	5005	Raybu	m Ct. C	p. Syn	Mdzozs		
	MAY 0 9 199	15 Jalia drival	workerfall			_	V	, ,		



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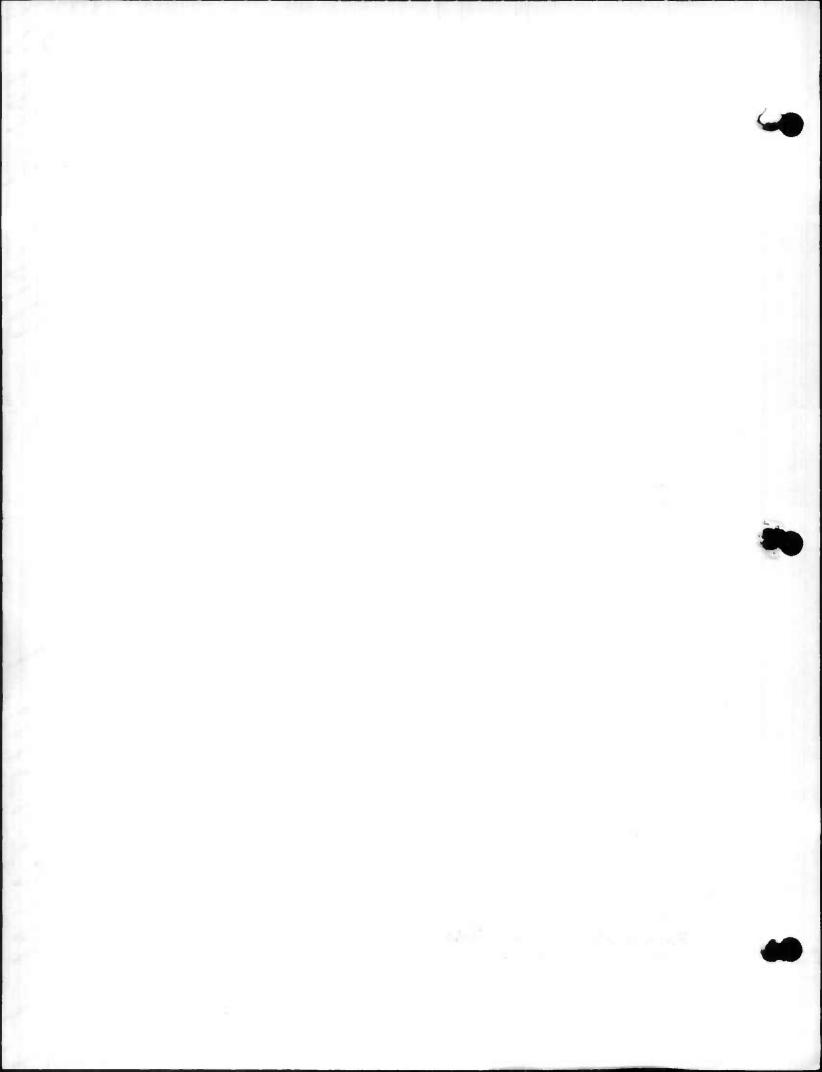
	. :	JOHN	J.	NOV	ABIL	SKI				APRTI.	DAY 26 19	YEAR	3. TIME OF DEATH
		SOCIAL SECURITY NUMBI				yrs. last birthday)	IF UNDER 1 YEA		A 24 HRS.	7 DATE OF BIRTH			PLACE (State or Foreign
	11—	176-46-2273		1 🖾 M 2 🗌 F	-	31 YRS.	MONTHS DAY	HOURS	MIN.	(Month, Day, Year) April 25,	1964		nsylvania
œ	1	PRINCE CE			CMTC	ם	96. CITY, TOW			ATH		NTTO OF DE	
CTOR	PRINCE GEORGE HOSP CENTER CHEVERLY MONTGOMERY												
DIRE	1	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								LIMITS?			
_	_	aryland STREET AND NUMBER	FIIICE	Georges		орре	er Mari	DOTO	ne .		too CIT	TZEN OF W	1 ₹ YES 2 □ NO
ERA	1	6253 Brookn	mead C	ourt				2077				ISA	THAT COOK THEY
BY FUNI	10	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D			YES	N U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RA 15. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, stc.)					14. RACE Black Specif	- American Indian, White, etc. by: White	
TED		15. DECE (Specify only	EOENT'S EDUC highest grade	completed) (Give kind of work done during most of working					ing	16b. KIND OF B	USINESS/INC	DUSTRY	
PLET	Elementary/Secondary (0-12)				Polic	e Offic	er		Princ	e Geo	roes	County	
COMPL	17.	FATHER'S NAME (First, Mic	iddle, Last)				0 01111	-	HER'S NAI	ME (First, Middle, Meide		- 500	Councy
BE C	В	ernard J. N	Novabi	lski				Joa	anne	M. Ezzo			
0		. INFORMANT'S NAME (7)	. ,							loute Number, City or To			20772
		aren Novabi			200 0	LACE AND DATE			ourt,	Upper Ma			
	1 2	Burlal 2 Cremation Donation 6 Other	n 3 🗆 Remo	oval from State		ery, cremetory or o			em.	5/1/ Boy	ocation -		
	21.	SIGNATURE OF UNERAL	SERVICE LIC	ENGE 11			22. NAME	AND ADDRE	ESS OF FAC	Hines-R	inald		neral Home
		- Maly	12/	Wolde	-		1180 Silv	00 Nev er St	v Ham oring	pshire Av , Marylan	enue d 20	904	
TIFICATION	dis	MEDIATE CAUSE (Find sease or condition suiting in death)	+	DUE TO (OR AS A O	Ple DESEOUENCE OF	Cen	sLd	- 0	landi	5		intarval Between Onset and Death
EHTIFICATI	if car CA thi	nav, leading to immed use. Enter UNDERLYih USE (Disease or injur at initiated events suiting in death) LAST	flate NG ry			ONSEQUENCE OF							
	if a	any, leading to immed use. Enter UNDERLYIN USE (Disease or injur at initiated events	diate NG Py	DUE TO (1	OR AS A C	ONSEQUENCE OF	-]:	ing ceuse	given in l		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
- 1	if a	any, leading to Immed use. Enter UNDERLYIN USE (Disease or injur at initiated events putting in death) LAST	diate NG Py	DUE TO (1	OR AS A C	ONSEQUENCE OF	-]:	ing ceuse	given in l	PERFO	N AUTOPSY PRMED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	if can CA the res	any, leading to immed use. Enter UNDERLYIN USE (Disease or injur at initiated events suiting in death) LAST RT II. Other alignifican	flate NG ry	DUE TO (OR AS A Co	ONSEQUENCE OF	n the underly			YES	RMED?	24b.	AMILABLE PRIOR TO
: MEDICAL	CA CA this res	any, leading to immeduse. Enter UNDERLY IN UNSE (Disease or injurat initiated events suiting in death) LAST	flate NG ny r condition	DUE TO (OR AS A Co	not resulting	in the underly	□ UNG		YES	RMED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
: MEDICAL	CA CA this res	any, leading to immed use. Enter UNDERLYIN USE (Disease or injur at initiated events suiting in death) LAST RT II. Other alignifican	flate NG ny r condition	DUE TO (1) a contributing to (2) RIBUTE TO CAU	OR AS A Code of the Code of th	not resulting DEATH YE	in the underly S NO N (Check only or	UN(CERTAIN	PERFC 1 YES	RMED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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BE COMPLETED BY PHYSICIAN: MEDICAL	PA 25.	INV. isading to immeduse. Enter UNDERLY in USE (Disease or injurat initiated events suiting in death) LAST II. Other alignifican DID TOBACCO US WAS CASE REFERRED TO EXAMINER? 1 2 YES 2 NO MANNER OF DEATH Netural 5 P R Netural 5 P R Netural 6 C C C C C C C C C C C C C C C C C C	SE CONTRO Pending Investigation Could not be letermined DEFINE PHYSIC CAL EXAMINES	DUE TO (1) A CONTRIBUTE TO CAU HOSPITAL: 1 Inpetient 2 28s. DATE OF building, e	JSE OF 26. ER/Outpeti	DEATH YE PLACE OF DEAT All home, farm, sign, death occurrend/or investigation	in the underly S NO TH (Check only or OTHER: 4 Nursing H E OF 28c. URY M 1 Intreet, factory, of	UNC e) ome 5 R NJURY AT VORK? YES 2 [lica tea and piece death occu 29c. Lic	certain esidence NO n	PERFC TYES TOTHOR (Specify) 28d. OESCRIBE HOW 28f. LOCATION City or Toyag, State 10 the ceuse(s) and m time, data and pieca, to BER	INJURY POL	CURED SI TO Rural Pa Lod. Te cause(s) E SIGNED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY									YEAR	3. TIME OF DEATH				
	Jack Smit	h Nyla	nder						- 1	MONTH 5	09			12:43 A M
- 1	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER		IF UNDER		7. DATE OF BI	RTH	8. BIRTHPLACE (State of		PLACE (State or Foreign
	168-22-750	3	1 St M 2 - F	6	55 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, 7-21-)	1929		Rida	eway, Pa.
	9e. FACILITY NAME (If not institution, give street end number)					9b. CITY,	b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEAT							
DIRECTOR	NorthHampton Manor Nursing Home				9	Frederick Frederick						The second second		
S	10e. STATE 10b. COUNTY			10c, CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY	
E	W.Va. Jefferson				(Th	arles	т по	T.DO			LIMITS?			LIMITS? 1 YES 2 NO
	10e, STREET AND NUMBER				CII	artes	-	r. ZIP COD	E	10g. CITIZEN OF W			2.5	
FUNERAL	276 Tuscawilla Hills							2541		U.S.A.				
2	11. MARITAL STATUS		12. WAS DECEDEN	T EVED IN II C	APMED	I 42 V	MC OF			C ORIGIN? (Sp	nolfu Van			— American Indian,
	1 Never Married 2 🔯	Married		YES 2		101	f yes, sp	ecity Cuba	n, Maxican	Puerto Rican,			Black	, White, atc.
BY	3 Widowed 4 Divo	rced	IF YES, GIVE Y	WAN ON DAIES		-1'	☐ YES	S K NO	Specify:				Spech	White
0	15. OEC	EDENT'S EDUC	CATION	16a.	DECEDENT'S	USUAL OC	CUPATI	ON		16b. KINC	OF BUSI	NESS/INC	DUSTRY	
COMPLETED	(Specify online Elementary/Secondary (6	y highest grade	College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done a se retired.)	during mo	ost of working	ng					
7	unknown				3ookke	eper				Re	esta	ıran	t	
OM	17. FATHER'S NAME (First, M	liddle, Last)				-		18. MOT	HER'S NAM	E (First, Middle,				
	Carl Emil	Nylande	er					Ed	na E.	Smith	1			
BE	19a, INFORMANT'S NAME (1	ype/Print)			19b. MAILING	ADDRESS	(Street	and Numbe	r or Rural Ro	oute Number, Cit	ty or Town,	State, Zip	Code)	
2	Nancy B. N	ylande:	r		276	Tusca	awi1	1a H	ills.	Charl	les ^r	Pown	. WV	25414
	20e. METHOO OF OISPOSIT	ION	and the second	20b. PLA	CE OF DISPO	SITION (Na	me of ce	metery, crer		0.10.2			ON — City or Town, State	
		☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State offer in Ed.				11 Ce	emet	ery		Charles Town, W.Va.				
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	0		22.1	NAME A	ND ADDRE	SS OF FAC	ILITY	~-			
	Melvin T. Strider Co. P.O. Box 388, Charles Town, W.Va.						05414							
-	23. PART I, Enter the	1	/\/	mor	doesh Do									Approximete
	ehock, or h	eart failure.	Liet only one ce	use on each	line.	not enter	the in	oue or dy	mg, acci	aa caruiec (or realpin	atory an	I dot,	Intervel Between
	IMMEDIATE CAUSE (Findisease or condition	nai	1.1	. 1	4	_	/ .		/		-			Onset end Death
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un.	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
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MEDICAL	PART II. Other aignifica								given in i	Part I. 24a.	PERFORI		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Ingulia	Klipe	edles	Kuk	Cy M	elle	del			10	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
ME	Kneum									_				1 TYES 2 NO
ä	Cerebral	pen	mortege	-4/9	S									
CE	25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL	HOSPITAL:			ОТНЕ		LACE OF I	DEATH (Che	ck only one)				
KSI	1 TYES 2 NO		1 Inpetient 2	ER/Outpetlen	t 3 🗆 DOA	4 Denum	sing Hor	ne 5 🗆 R	asidence i	Other (Spe	ecify)			
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED									28d. DESCRIB	BE HOW IN	JURY OC	CURED	
	. /									- M	un	01	3	
2 Accident								Number or Rural Route Number,						
	1 Natural 5 2 Accident 3 Suicide 8	Investigation Could not be	28e. PLACE				tory, offi	ce		28f. LOCATION	N (Street a	nd Numbe	or or Rural I	Route Number,
8	1 Netural 5 2 Accident	Investigation	28e. PLACE	OF INJURY - A			tory, offi	ce		28f. LOCATION City or Tox	N (Street a wn, State)	nd Numbe	or Or Rural I	Route Number,
8	1 Netural 5 2 Accident 3 Suicida 8 4 Homicide 29a. CERTIFIER (Check only)	Investigation Could not be determined	28e. PLACE	OF INJURY — A	t home, farm,	street, fact			e, and due	City or Tox	wn, State)			Route Number,
8	1 Netural 5 2 Accident 3 Suicida 8 4 Homicide 29a. CERTIFIER (Check only 1 CER	Investigation Could not be determined TIFYING PHYS	25e. PLACE building	OF INJURY — A , atc. (Specify) of my knowledge	t home, farm,	street, fact	lime, dat	e and place		City or To	wn, State)	ner as sta	nted.	a) and manner as stated.
COMPLETED	1 Netural 5 2 Accident 3 Suicida 8 4 Homicide 29a. CERTIFIER (Check only 1 CER	Investigation Could not be determined TIFYING PHYSI	25e. PLACE building	OF INJURY — A , atc. (Specify) of my knowledge	t home, farm,	street, fact	lime, dat	e and place death occu	CENSE NUM	City or To- to the cause(e) lime, date and BER	and men	ner as sta I due to t	nted. the cause(s	a) and menner se stated.
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BE COMPLETED	1 Netural 5 2 Accident 3 Sulcida 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITL	Investigation Could not be determined TIFYING PHYSI PICAL EXAMINE	25e. PLACE building	OF INJURY — A sec. (Specify) If my knowledge examination and	t home, farm,	red at the t	ilme, dat	s and place death occu	ENSE NUM	City or To-	and men	ner as sta I due to t	nted. the cause(s	a) and menner se stated.
BE COMPLETED	1 Netural 5 2 Accident 3 Sulcida 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MED 29b. SIGNATURE AND TITL	Investigation Could not be determined TIFYING PHYSI PICAL EXAMINE	28e. PLACE building	OF INJURY — A sec. (Specify) If my knowledge examination and	t home, farm, o, death occur Vor investigati	red at the t	ilme, dat	s and place death occu	CENSE NUM	City or To-	and men	ner as sta I due to t	nted. the cause(s	a) and manner se stated.



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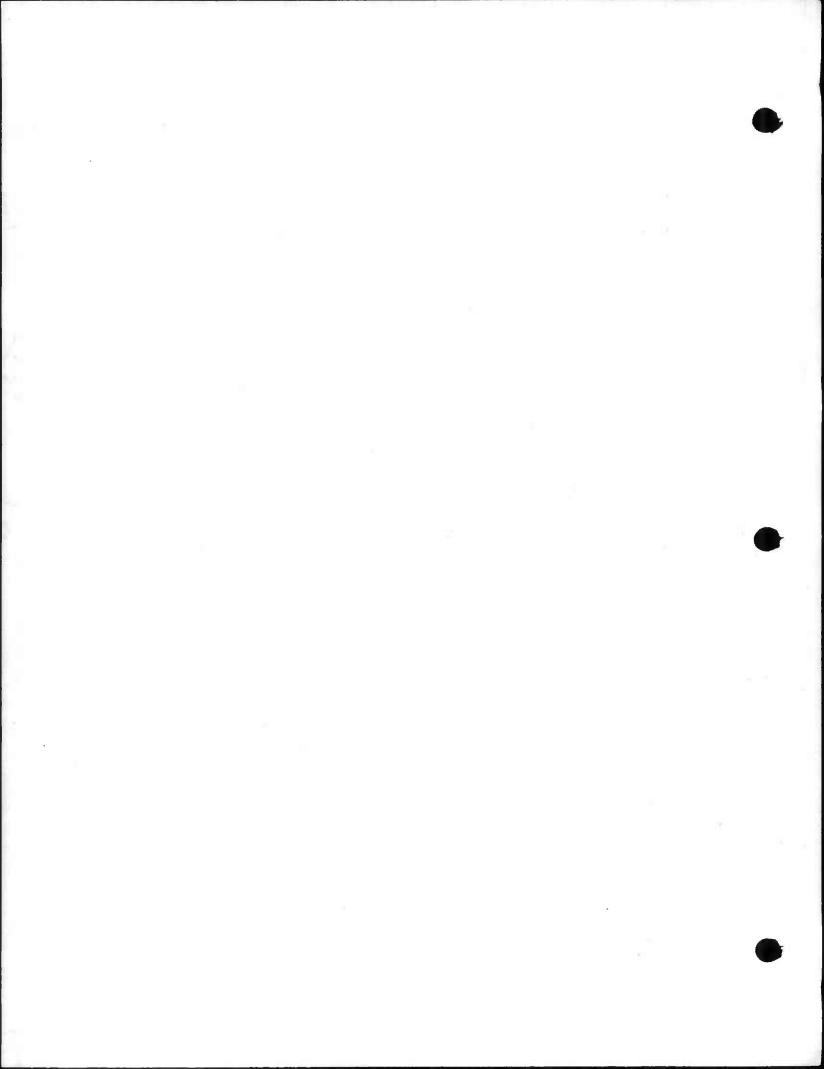
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH .00 AM Michael Shane Norris May 1995 4. SOCIAL SECURITY NUMBER 5. SEX 5. AGE (In yrs. last birthday) 5. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. DAYS HOURS 215-56-1661 1 X M 2 1 26, Mar. 1948 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 222-C Robin Hood Road Havre de Grace Harford 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford 1 - YES 2 NO permit. Havre de Grace FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 222-C Robin Hood Road 21078 USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 ☐ YES 2 ☐ NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White Vietnam ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Material inspector County Dept. of Works notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) BE Wilbur Norris Gertrude Lowe 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21078 Mrs. Susan M. Norris 222-C Robin Hood Road, Havre de Grace, MD e 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 208. METHOD OF DISPOSITION

1 Burlet 2 T Cremation 3 Removal from State
4 Donation 5 Other (Specify) must ery, cremetory or other piece)
A. Ferris & Co., Inc. 5/9 West Chester, PA the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. hours after death. Buste Aberdeen, Maryland 21001-3399 silona that calved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23. PART i. Enter the diseases, or complici Approximata ahock, or heart failure. List Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition ARCINOMA resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATHT 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 DR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check unly one) HOSPITAL OTHER T VES 2 100 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA E ☐ Other /Specify 0 27. MANNER OF DEATH 28s, DATE OF INJURY (Month, Day, War) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Fretural M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY -- At home, farm, street, factory, office 3 Suicide 29f. LOCATION (Street and Number or Rural Route Number City or Town, State) 99 COMPLETED 6 Could not be 4 [] Homicide Item 28 death occurred at the time, date and place, and due to the cause(s) and manner as stated. THE HOSPITAL I THE FUNERAL C filed within 72 h TO THE FUNERAL DE filed within 72 h HOSPITAL etion, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) X

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pripe)

32. REGISTRAN'S SIGNATURE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execut	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
		Nix				MAY	6 199	3 300 11	
			-	ONTHE DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign ountry)	
		1 M 2 F 5	YAS.			June 18,	1935	Virginia	
Œ	99. FACILITY NAME (If not institution, give streets Southern Maryla				R LOCATION OF DE	EATH	9c. COUNTY (
DIRECTOR	RESIDENCE OF DECEDENT	nu Hospita	11	CII	nton		Princ	ce George's	
REC	10a. STATE 10b. COUNTY	STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION							
		rles		Waldo	rf			LIMITS?	
FUNERAL	10e. STREET AND NUMBER		""	101		10g. CITIZEN	OF WHAT COUNTRY?		
NE	2002 Gallery Pl				206	02	U	JSA '	
F	11. MARITAL STATUS 1 □ Never Married 2 🔯 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2NO	If yes, sp	ecify Cuban, Maxica	HC ORIGIN? (Specify Yes	RACE — American Indian, Black, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES ^	1 TYES	2 NO Specify	y:		Specify: White	
COMPLETED	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION	16a. DECEDENT'S US	SUAL OCCUPATION	ON	16b, KIND OF BUS	SINESS/INDUSTF		
7		College (1-4 or 8+)	(Give kind of wor life. Do NOT use i	k done during mo retired.)	st of working	550000000000000000000000000000000000000			
MPI	10		Waitres	S		Rest	aurant	:	
Ö	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
BE	Amos M. Hicks					essa Bai			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town			
	Freddie M. Nix					e, Waldo			
	1 Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State came	PLACE AND DATE OF stery, crematory or othe	r olace)			CATION — City of		
a Ú	21. SIGNATURE OF EUROPAL SERVICE LCEN	mer /	<u>'rinity</u>		LAL GOS	5-10 Wa	ldort,	MD	
11	1390111	Much	abla			al Home			
	Benjamin M		100658	P. 0	. Box 1	56, Wald	orf, M	ID 20604-015	
	23. PART i. Enter the diseases, or cor shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	Respute	tors (enter the mo	de of dying, auc	h aa cardiac or respi	ratory arrest,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Due to (or As A consequence or): Due to (or As A consequence or):								
PHYSICIAN: MEDICAL	Divers &	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 VES 2 NO VES 2 VES 2 NO VES 2 VES 2							
ä	DID TOBACCO USE CONTRI				UNCERTAIN	1 🗆			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH	(Check only one)					
YSI	1 VES 2 NO 1	Inpatient 2 - ER/Outpa			5 Rasidence	6 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME C	Y WO	RK?	28d. DESCRIBE HOW II	JURY OCCURE		
BY	2 Accident Investigation	280. PLACE OF INJURY	At home to star		ES 2 NO				
8	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Specif	y)	et, ractory, omici		26f. LOCATION (Street a City or Town, State)	nd Number or Ru	ral Route Number,	
COMPLETED	29e. CERTIFIER								
MP	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowle							
	296. SIGNATURE AND JITLS OF CERTIFIER	The state of gazannesson		T my opinion, u			due to the cau	se(s) and manner as stated.	
BE	STATISTICS AND THE OF CENTIFIER	Idam	ms		29c. LICENSE NUM	IBER	29d. DATE SIGI	NED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEA	TH (ITEM 27) /3ma 0-	int	12/19.	17	- //	1/aux 1745	
	71 60011	/ 41 1	131.00	Bail	1 1	00 R.	11	Gazz MA	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		MAN	of knove	W. WRE	MATIL	1000 110	
	MAY 0 9 1995	Talia d'avoles	or Rardall		/			00012	

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Ours after death. Page 6 may be retained by the hospital or attending physician. In the fundral director page 5, should be described by use as the brief broad of in the fundral director page 5, should be described by use as the brief broad by TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Account after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE OF STATE OF	MARYL	AND / DEPA CERTII	RTMENT OF	HEALTH AND I	MENTAL HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN	_	3. TIME OF DEATH		
	GARLAND NOCK					4- 28-		7:15a M		
-	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, War)						8. BIRT	BIRTHPLACE (State or Foreign Country)		
		214-10-8582 1 X 2 1 94 YRS. 10-5-1						VIRGINIA		
œ	229 CANAL PARK DR	9a. FACILITY NAME (If not institution, give street and number) 229 CANAL PARK DR a 9b. CITY, TOWN OR LOCATION OF DEATN SALISBURY WIC								
6	RESIDENCE OF DECEDENT	DDORT			OHICO					
DIRECTOR	10s. STATE 10b. COUNTY WICOMIC	10c. CI	TY, TOWN OR LOCA	SBURY			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
	100. STREET AND NUMBER	0			Of, ZIP CODE		100 CITIZEN OF	1 YES 24 NO		
FUNERAL	229 CANAL PARK DR	ΔPr	т. 206	- 1	21801		U.S			
5	11. MARITAL STATUS 12. WAS DECE	ENT EVER I	U.S. ARMED		CENOENT OF HISPAN	NIC ORIGIN? (Specify Yea	or No.— 14. RAC	E — American Indian,		
ВУ Б		1 YES			S 2 NO Specify	n, Puerlo Ricen, etc.) y:		ck, White, etc.		
	15. OECEDENT'S EQUICATION	15. OECEDENT'S EQUICATION 18e DI				16b. KIND OF BUS	BINESS/INDUSTRY			
Ē	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 of	7 5 +)	(Give kind o	work done during n	ost of working					
COMPLETED	2		BUS:	INESSMA	N	SELF-	-EMPLOY	ED		
	17. FATNER'S NAME (First, Middle, Last) WILBUR S. NOCK					ME (First, Middle, Maiden				
BE	190. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street		Route Number, City or Town				
임	RICHARD S. WOOTTE	N			H BANKS			MD. 21801		
	20e. METNOD OF DISPOSITION 1 □_Burlel 2 □ Cremation 3 □ Removal from State		PLACE AND DATE	E OF DISPOSITION (lame of	OATE 20c. LO	CATION — City or T	own, State		
	4 Donation 5 Other (Specify)		WICOM	CO MEM			ALISBUR	Y,MD.		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	7	0 -		ND ADDRESS OF FA					
	Duald (10	Men	2				*	SBURY, MD.		
	23. DART i. Enter the diseases, or complications shock, or heert fellure. List only one	ihai caueac cauae on e	d tha death, Do ech iina.	not enter the m	ode of dying, auc	h aa cerdiec or respi	ratory erreat,	Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition	MMEDIATE CAUSE (Final lesses or condition								
	disease or condition resulting in death) • Artesioscleratic Cerebro Vascular Disease URa Due to (or as a consequence of):									
Z	Sequentially list conditions, b.									
CERTIFICATION	If any, leading to immediate cause, Enter UNDERLYING	TO (OR AS A	CONSEQUENCE	OF):						
잂	CAUSE (Disease or Injury C.	TO (OR AS A	CONSEQUENCE	OF):						
ERI	resulting in death) LAST									
AL C	PART II. Other aignificent conditions contributing	to death b	ut not resulting	In the underlyi	ng ceuse given in	Part I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS		
2	Carcinoma of Pro	tate	2			PERFOR 1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE		
MEC								OF DEATH? 1 YES 2 NO		
ÿ	DID TOBACCO USE CONTRIB	UTE TO	CAUSE C			· ·				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input lant			OTHER:	LACE OF DEATH (Ch					
PHYSICIAN: MEDIC	27. MANNER OF GEATH 28s. OATS	OF INJURY	patient 3 DOA	ME OF 28c. IN	me 5 XReeldence	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED			
ВУР	1 Natural 5 Pending (Montal 2 Accident Investigation	h, Day, Year)	10	UJURY W	ORK? YES 2 NO					
	3 Suicide 8 Could not be 28s. PLAC	E OF INJURY	— At home, farm	, atreet, factory, off	C0	28f. LOCATION (Street e City or Town, State)	and Number or Rural	Route Number,		
COMPLETED	4 Homicide determined									
MP.	(Check only one)									
ō S	2 MEDICAL EXAMINER: On the basis	of examination	n end/or investigat	ion, in my opinion,	_					
BE	296. SIGNATURE AND TITLE OF CERTIFIER	12.1	· PP.		29c. LICENSE NUM	008	29d. DATE SIGNE	D (Month, Day, Year)		
일	SE NAME AND ADDRESS OF PERSON WING COMPLETED	AUSE OF DE	ATHAITEM 27) (3/	M. Print	1000		172	.8/45		
	THOMAS C. HILLIR 10	8 Pi	NEB)U	FFRd	Salisbo	URY, Md	2180	11		
	31. DATE FILED (Morth, Dev. Year) APR 2 8 1995 January	TRAN'S SIGN	ATURE PLANTAL							
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		1 - STATE REGISTRAR	STATE OF MANTE	CERTIF	ICATE OF	DEATH	MENIAL HTG REG.				
		1. DECEDENT'S NAME (First, Middle, Last,	OSTERH	NIT			2. DATE OF DEAT		95 /	TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yra			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLA	ACE (State or Foreign	
2		088-24-9637	1 □ M 2 😾 F 72	2 YRS.	MONTHS DAYS	HOURS MIN.	July 8.		Country)	ridge. N.Y	
should	-	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF			TY OF DEAT		
1, 2, 3	ē	Larkin Chase N	ursing Center	c	Bowie			Prin	ce Ge	orge's	
Pages	DIRECTOR	16a. STATE 16b. COUNT	ry	10c. CF	TY, TOWN OR LOC	ATION		10d. IN			
£.			nango	Ba:	inbridge			1			
it permit.	FUNERAL	10e. STREET AND NUMBER			1	01. ZIP CODE		10g. CITIZ	EN OF WHA	T COUNTRY?	
020 physician. burial-transit	NE I	Rd 2 Box 55	12. WAS DECEDENT EVER I	NUS ARMED	12 WAS DE	13733	NIC ORIGIN? (Specif		USA		
	ВУ	1 Never Married 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, a	pecify Cuban, Mexic S 2 NO Spec	an, Puerto Rican, etc	/ Yes or No-	Black, W Specify:	American Indian, hite, atc. White	
21 8 mg 21	ED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	16a. DECEDENT'S	B USUAL OCCUPAT	TION	16b. KIND OF	BUSINESS/INDI		VIIICC	
	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	ise retired.)	iod of Worlding					
AND 2 he hospital detached to once.	COMPL	17. FATNER'S NAME (First, Middle, Last)	44	Nurse	e R.N.			Care	Indust	ry	
# 8 E	ECC	Charles Armstro	ng			227	AME (First, Middle, Ma				
MAR retained 1 5 should	TO BI	19a, INFORMANT'S NAME (Type/Print)		196. MAILING	O ADDRESS (Street	and Number or Rural	he Pooler Route Number, City or	Town, State, Zip	Code)		
9 5 5 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	F	Carl Osterhout		RD 2	Box 55	Bainbrid	ge, New Y	ork. 1	3733		
- 9 A		20e. METNOD OF DISPOSITION 1 □ Buriel 2 🔀 Cremetion 3 □ Ren	noval from State Can	b. PLACE AND DATE	OF DISPOSITION (A	Name of	DATE 200	LOCATION — C		State	
		4 Donation 6 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE L	Me	tropolit	an Crem	atory 4-3		<u>lexandr</u>	ia, V	irginia	
ALTIN death. Pag tuneral di tuneral di tuneral di examiner					Robe	rt E. Ev	ans Funer	al Home	, P.A.		
AN - 2 M		23. PART i. Enter the diseases, or	Evans: P.	res.	1600	O Annapo	lis Road	Bowie,	Md. 2	20715	
within 24 hour pletely filled is cremation, or nent, the me		iMMEDIATE CAUSE (Final	. List only one ceuse on a	ech line.	1	4	ch ss cerdiac or n	aspiratory arre	st,	Approximats Interval Between Onset and Death	
certificate be executed in the physician and of hygiene prior to burian or other traumatic	ERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequentially list conditions, if sny, leading to immediate cause. Due to (or as a consequence or): Due to (or as a consequence or): Commonwealth Last									
he death the atte Mental	0	PART II Other significant condition	no contribution to death to	7.90	0						
NECORDS, w requires that the dea been signed by the att it, of Health and Menta shows any Injury,	MEDICAL	PART II. Other significant condition					PER	S AN AUTOPSY REFORMED? S 2 (1) NO	AWA COI OF	RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE DEATN? YES 2 NO	
law law	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O				N 🗆				
N: The State	SICI	EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:						
rSicia certif	РНҮ	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIN	E OF 28c, IN	JURY AT	6 Other (Specify) 28d. DESCRIBE NO	OW INJURY OCCI	JREO		
VOING PHYS After this of the death with the death dea	B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28e. PLACE OF INJURY		M 1 🗆	ORK? YES 2 NO	28f. LOCATION (Str				
ON STENDING DIRECTOR: After hours after death item 28 is ma	ETED	4 Nomicide determined	building, atc. (Spec	cny)			City or Town, S	tele)		Number,	
THE HOSPITAL O THE FUNERAL DI filed within 72 ho PORTANT: II 11e	COMPL	2 MEDICAL EXAMIN	BCIAN: To the best of my know ER: On the basis of examination	riedge, death occurr on and/or investigation	ed at the time, date on, in my opinion,	e and place, and due death occured at the	to the cause(a) and time, date and place	menner as state	d. ceuse(a) and	d menner as stated.	
TO THE I	TO BE	29b. SIONATURE AND TITLE OF CERTIFIE	icalR, M	D PAUL	DR. BERE	29c. LICENSE NU 2 D 44	MBER 38	≥ 4	SIONED (MOI 1-29-	nth, Day, Year) -95	
(10)		66. NAME AND ADDRESS OF PERSON WE 134 EWENSV	MERD	W1257	RIVER	es mo	20778	3			
	į	31. DATE FILED (Month, Day, Year)	33 REGISTRAR'S, SIGN	ATURE							

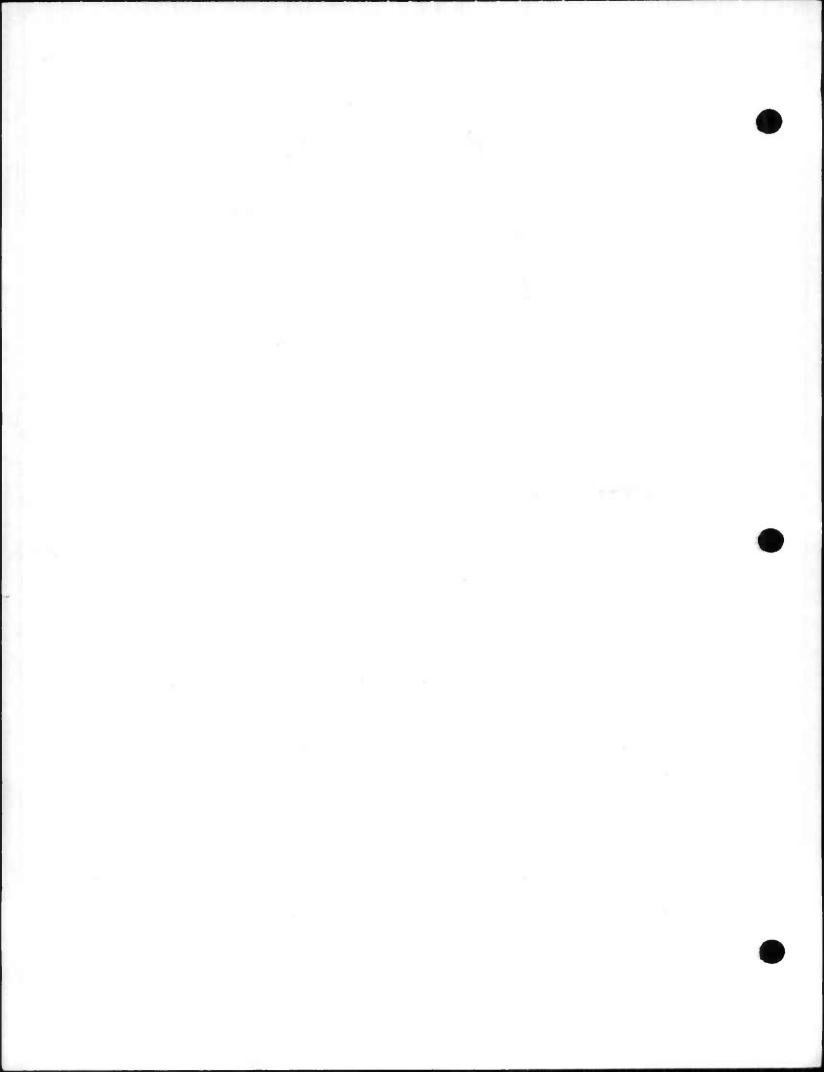
DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

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		MARY LYNN OLIVER May 2, 1995 YEAR										3. TIME OF DEATH 8:00 A			
_		4. SOCIAL SECURITY NUMBER 430-84-110		5. SEX		yrs. last birth	MONTH	DER 1 YEAR S DAYS		R 24 HRS.	7. DATE O		1945	8. BIRTHE Country Texa	PLACE (State or Foreign) 3. S
2, 3 should	TOR N	90. FACILITY NAME (If not in 12909 Bucca	aneer 1						or Locat				ec. county of DEATH Montgomery		
permit. Pages 1,	DIRECTOR	RESIDENCE OF DEC 10a. STATE Maryland	10b. COUNTY				10c. CITY, TOWN OR LOCATION Silver Spring								10d. INSIDE CITY LIMITS? 1 YES 2 NO
nsit permir	COMPLETED BY FUNERAL	100. STREET AND NUMBER		Road			101. ZIP CODE 20904					10g. CITIZEN O USA			
enoing prysician. as the burial-transit		11. MARITAL STATUS 1 Never Married 2 2 3 Widowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 (4NO	MED 13. WAS DECENDENT OF HISPANIC If yes, specify Cuban, Mexicon, 1 YES 2 NO Specify:				en, Puerto Ri	, Puerto Rican, etc.) Bia			- American Indien, White, etc.
ed for use as		15, DEC (Specify on Elementary/Secondary (0 1 2	EDENT'S EDUC y highest grade 0-12)	CATION completed) College (1-4 or 5		(Give kin tite. Do N	NT'S USUAL d of work dor OT use retired	ne during i f.)	TION most of world	ing	16b.	KIND OF BUS	Home		WILLE
S should be detached for use notified at once.		17. FATHER'S NAME (First, M Melvin J.	Ireland	1					Ma	rgar	et Tr	ueba	Sumame)		
y or retained bage 5 should be notified	101	Robert A. (Oliver			1290	9 Bu	ccan	eer R		Silv	er Sp	ring,	MD	20904
ector, p		20c. METHOD QE DISPOSITION 1 Burlel 2 Cremellon 3 Removal Irom State 4 Donallon 6 Other (Specify) 20c. LOCATION - City or Town, State FORT LINCOLN Crematory 5/6 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HINES-Rinaldi Funeral Homes											ryland		
n by the funeral dir removal.		▶ @neth	on,	S. Di	m			1180 Silv	0 New er Sp	v Han	npshi: g, Ma:	e Ave	nue 209	904	ierai nome
y filled in tion, or re		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abook, or heart feiture. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Disease Relapsed. 347 Sequentially list conditions, OUE TO IMAS A CONSEQUENCE OF):													
ending physician and Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. OUE TO (M AS A CONSEQUENCE/OF): DUE TO (OR AS A CONSEQUENCE OF): d.													
n signed by the atter f Health and Mental I	MEDICAL C	PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. Respectory Completion of Cause of Part ii. Performed? 1 yes 2 pt No 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										MAILABLE PRIOR TO COMPLETION OF CAUSE			
s certificate has been s th the State Dept. of H id, or Item 23 shov	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
fer this certifical eath with the St marked, or it	РНУ	1 🗆 YES 2 NO 27. MANNER OF DEATH 1 📝 Netural 5 🗀	Pending	HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D	INJURY		TIME OF INJURY	28c. III	JURY AT		6 Other	(Specify)	JURY OCC	URED	
after d	TED BY	2 Accident 3 Suicida 6	investigation Could not be determined	26e. PLACE O building,	F INJURY — atc. (Specify)	Al home, la	rm, street, la		YES 2	□ NO	261. LOCAT	TON (Street e. Town, State)	nd Number (or Rural Ro	ute Number,
120 -	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFIER 2 MEDI	CAL EXAMINE	CIAN: To the best of	my knowleds	ge, death oc	curred at the	time, de	te and place	, end due	to lhe cause time, deta a	e(a) end man	ner se state I due to the	d, cause(a)	and manner ee stated.
TO THE FUNERA De filed within 7	TO BE	29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	as		of or other				29c, LICI	292	48ER		29d. DATE	SIGNED (Mgnth, Day, Year)
		EVERAS 31. DATE FILEO (Month, Day.	2D H	frou	石	100	310	Co	nn-	Aer	nne.	KEN.	SINGT	W V	1) 20895
l		MAY	04 199	5 Julia 6	Devolso	x-Rando	4								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO PORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

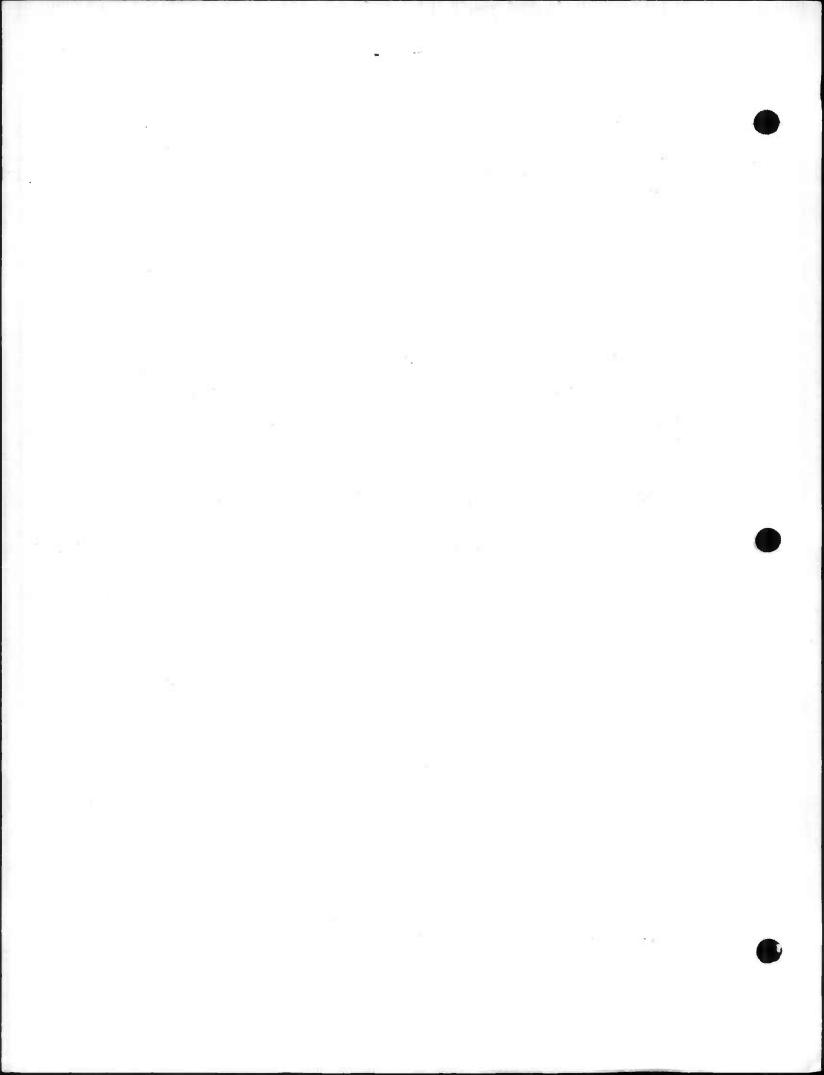
STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH A	ND	MENTAL	HYGIEN
		C	ERTIFICATE	OI	F DEATH	4		REG. NO

1 - STATE REGISTRAR	OITHE OF MINHTEN		CATE OF		REG. NO.						
t. DECEDENT'S NAME (First, Middle, Last)		-		DEATH	2. DATE OF DEATH		3. TIME OF DEATH				
MARY	ORCHARD				APR 22	" 1995 "	3:20 PM				
4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	0. 6	HRTHPLACE (State or Foreign				
178-18-8835	t □ M 2 😾 F	0 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		ountry) FNNCVT.VANTA				
	178-18-8835 TIME 2XF 90 YRS. JAN. 8, 1905 PENNSYLVAN 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										
WILLIAM HILL HE RESIDENCE OF DECEDENT 104. STATE 106. COUNTY PENNSYLVANIA	WILLIAM HILL HEALTH CARE CENTER EASTON TALBOT										
tos. STATE tob. COUNTY											
E PENNSYLVANIA I	PHILADELPHI	га т	PHILADE	T.DHTA			LIMITS?				
	TITELLE III			ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
450 ROBBINS AVI	MILE			1911	11		USA				
	12. WAS DECEDENT EVER IN L FORCES? t YES	J.S. ARMED	13. WAS DEC		NIC ORIGIN? (Specify Yes	or No- 14.	RACE — American Indian.				
t Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? t YES	2XXVO ES	If yes, sp		in, Puerto Rican, etc.)		Black, White, atc. Specify: WHITE				
ts. DECEDENT'S EDUCA	TION	8a. DECEDENT'S	USUAL OCCUPATION	IN .	16b. KIND OF BUS	SINESS/INDUST	RY				
(Specify only highest grade co	ompleted) College (1-4 or 5+)	(Give kind of w life, Do NOT us	vork done during mo e retired.)	st of working							
Specify only highest grade co	conege (14 of 54)	TELI	LER		BAN	KING					
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
JAMES FAIR RENN	NIE			MAI	RY DRYSDA	LE					
		19b. MAILING	ADDRESS (Street a	nd Number or Rural i	Route Number, City or Tow	n, State, Zip Cod	0)				
JUNE ORCHARD BE	EAR	324 I	PERRY C	ABIN DI	R., ST. M	IICHAE	LS, MD				
20a METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		ery, cremetory or of			4 20	CATION — City					
21. SIGNATURE OF FUNERAL SERVICE LICEN		TPTTRE	CEMETE 22, NAME AI	KY ID ADDRESS OF FA	L KUS	LYN,	PA				
					ERAL HOME	, P.A	•				
JOHN R. 1	MERCERON	J CFSP	200	S. HARI	RISON ST.	. EAS	TON.MD 21601				
23. PART i. Enter the diseases, or con shock, or heart fallure. Lit	mplications that caused t at Dnly Dne cause on eac	the deeth. Do n th line.	ot enter the mo	de of dying, suc	h es cardisc or respi	ratory srrest,	Approximate interval Between				
IMMEDIATE CAUSE (Final				_	2.5		Onset and Death				
disease or condition resulting in death) s.				gasi	_		24-48h				
	DUE TO (OR AS A C	ONSEQUENCE OF	7):	U	0	1					
Sequentially list conditions, b.	DUE TO (OR AS A C	OND COLUMN	00	uglen	2 Ylour	2 lus	35/1-2 Wh				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DOE TO (ON AS A C	ONSEQUENCE OF	-):		\						
CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	n:								
resulting in desth) LAST		.,,	,-								
d.											
PART II. Other significant conditions			The state of the s	cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
3 Denorale		cosa	ardie		t _ YES 2		COMPLETION OF CAUSE OF DEATH?				
vasules	dessos	0		_		,	t TYES 2 NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 1 1 1 1 1 1 1											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)						
I □ YES 2 NO	☐ Inpatient 2 ☐ ER/Output	ient 3 🗆 DOA	Nursing Hom	e 5 🗌 Residence	8 Other (Specify)						
Z MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ		URY AT RK?	28d. DEŞCRIBE HOW I	NJURY OCCURE	D				
Netural 5 Pending 2 Accident Investigation			M 1 🗆 1	ES 2 NO							
	28a. PLACE OF INJURY — building, etc. (Specify	At home, farm, s	street, factory, offic		26f. LOCATION (Street a City or Town, State)	and Number or R	ural Route Number,				
3 Suicide 8 Could not be detarmined 29a. CERTIFIER Check only one) MEDICAL EXAMINER:	l										
29a. CERTIFIER Check grily CERTIFYING PHYSICI	AN: To the best of pry timelec	ige, desth occurre	ed at the time, data	and place, and due	to the cause(a) and mar	mer as stated.					
One) MEDICAL EXAMINER:	On the besis of examination						use(a) and manner on stated.				
	(2.)		10 5E	29c. LICENSE NUI	WBER	29d. DATE SIG	NED (Month, Day, Year)				
WD1000	1) 1/201	711/	11	D2740			22.25				
2 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (1)/pe,	Print)								
LAWRENCE D. BOR	IAN, M.D.,	606 DI	JTCHMAN	'S LANE	E, EASTON	, MD	21601				
31. DATE FILED (Month, Day, Year)	32, REGISTRAR'S SIGNAT	URS			,	,					
31. DATE FILED (Month, Dey. Year) APR 24 1995	Jala Dandes	hardally									

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and requires that the death certificate be executed within to the function page in the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

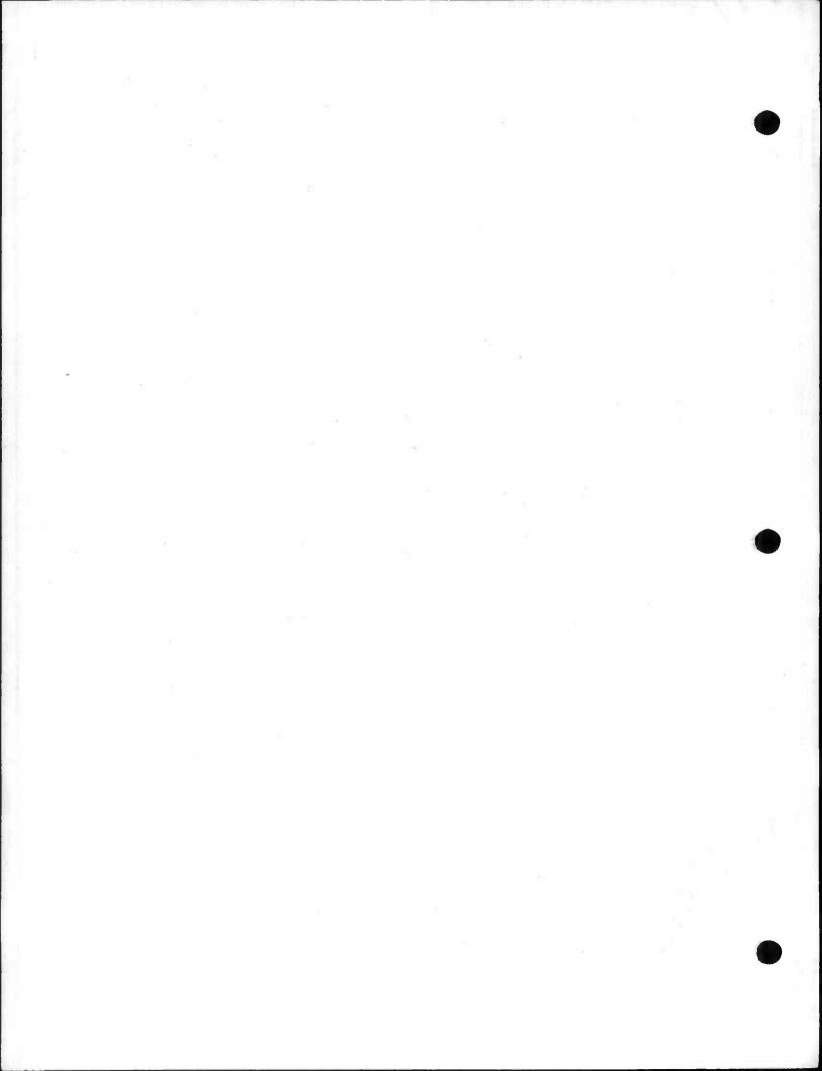
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR STATE REGISTRAR	STATE OF MARYL		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Las	u)			2. DATE OF DEATH		3. TIME OF DEATH
4	Lucille M.	O'Reilly			April 2	$\frac{8}{9}$, $19\frac{8}{9}$	5 10:25 AM
	4. SOCIAL SECURITY NUMBER			DER 1 YEAR F UNDER 24 HRS.	7. DATE OF BIRTH	8, 8	BIRTHPLACE (State or Foreign
22	232-68-0182		2 YRS. MONTH	B DAYS HOURS MIN.	Sept. 24		New Jersey
-	9a. FACILITY NAME (If not institution, giv	e street and number)	9b. C	ITY, TOWN OR LOCATION OF D		9c. COUNTY	
5 HO	6549 Green Wa	ay		Easton		Talb	ot
EC	10e. STATE 10b. COU		10c. CITY, TOW	N OR LOCATION	-		10d, INSIDE CITY
DIRECTOR	Maryland Ta	albot	East	on			LIMITS?
	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	6549 Green Wa	ìУ		21601		Unit	ed States
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES		13. WAS OCCENDENT OF HISPA If yes, specify Cuban, Maxic		n or No 14.	RACE American Indian, Black, White, atc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TES 2 TNO Spec			Specify:
	15. DECEOENT'S E	DUCATION	16a. DECEDENT'S USUAI	OCCUPATION	16h KIND OF BU	JSINESS/INDUST	White
ET	(Specify only highest gra Elementary/Secondary (0-12)	college (1-4 or 5 +)		ne during most of working	TOOL KIND OF BO	7511125571112057	
APL	12	4	Homema	aker			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				AME (First, Middle, Meider	Sumame)	
BE (Leo A. Lour	ney			lle Ren		
0	19a. INFORMANT'S NAME (Type/Print)			ESS (Street and Number or Rural			ie)
	Charles H. O'F		6549 Gi	een Way, E			
	20e METHOD OF DISPOSITION 1 Description 2 Cremation 3 Report to the second seco	emoval from State cor	PLACE AND DATE OF CISI	POSITION (Name of		CATION — City	or Town, State Maryland
	4 ☐ Donetion 5 ☐ Other (Specify)			22. NAME AND ADDRESS OF F		rora,	Maryland
- 8	•			Newnam Fun	eral Home		
	JOHN R.	MERCERON	CFSP	200 S. Har	rison St	., Eas	ton, MD 21601
		e. List only one cause on a	d the death. Do not en ech line.	ter tha moda of dying, su	ch as cardiac or resp	piratory arreat,	intarval Between
	IMMEDIATE CAUSE (Final disease or condition	01.0.41	tie Care	-			Onset and Death
	resulting in death)	a. PAMMAS	CONSEQUENCE OF):	. 0			1 4545
z		- 6					
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	CONSEQUENCE OF):				
2	cause, Enter UNDERLYING CAUSE (Disease or Injury	c					
E	that initiated events resulting in death) LAST	DUE TO (OH AS A	A CONSEQUENCE OF):				
CERTIFICATION		_ d.					1
	PART il. Other algnificant conditi	ona contributing to death b	out not resulting in the	undarlying cause givan in	Part I. 24a. WAS AI	N AUTOPSY RMEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
20					1 _ YES		COMPLETION OF CAUSE OF DEATH?
ME					/		1 YES 2 NO
ä							
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OTH				
14S	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Out	petient 3 DOA 4 1	Nursing Home 5 Residence			
	1 Natural 5 Pending	(Month, Day, Yeer)	INJURY	26c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURE	ED
BY	2 Accident Investigatio 3 Suicide 6 Could not b	26s. PLACE OF INJURY	— At home, farm, streat,		28f. LOCATION (Street	and Number or R	Tural Route Number
COMPLETED	4 Homicide determined	building, atc. (Spe	cify)		City or Town, State)	
7	29a. CERTIFIER (Check only	YSICIAN: To the best of my know	ledge, death occurred at th	se time date and place and du	s to the reveals) and me	anar an atalad	
M		INER: On the basis of examination					use(a) and manner as stated.
E C	296. SIGNATURE AND TITLE OF CERTIF			29c, LICENSE NU			GNED (Month, Day, Year)
00	Muhael 15	the M		D318		D 5/1	195
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	1 2310		-///	
	Michael J. Fi	sher, M.D.,	505 Du	tchmans La	ne, East	on. M	D 21601
	Michael J. Fi 31. DATE FILED (Month, Day, Year) MAY 01 1995	sher, M.D.,	505 Du	tchmans La	ne, East	on, M	D 21601



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	PHYSICIAN:
יייייייייייייייייייייייייייייייייייייי	OR ATTENDING PHYSICIAN:
	S.
	TAL

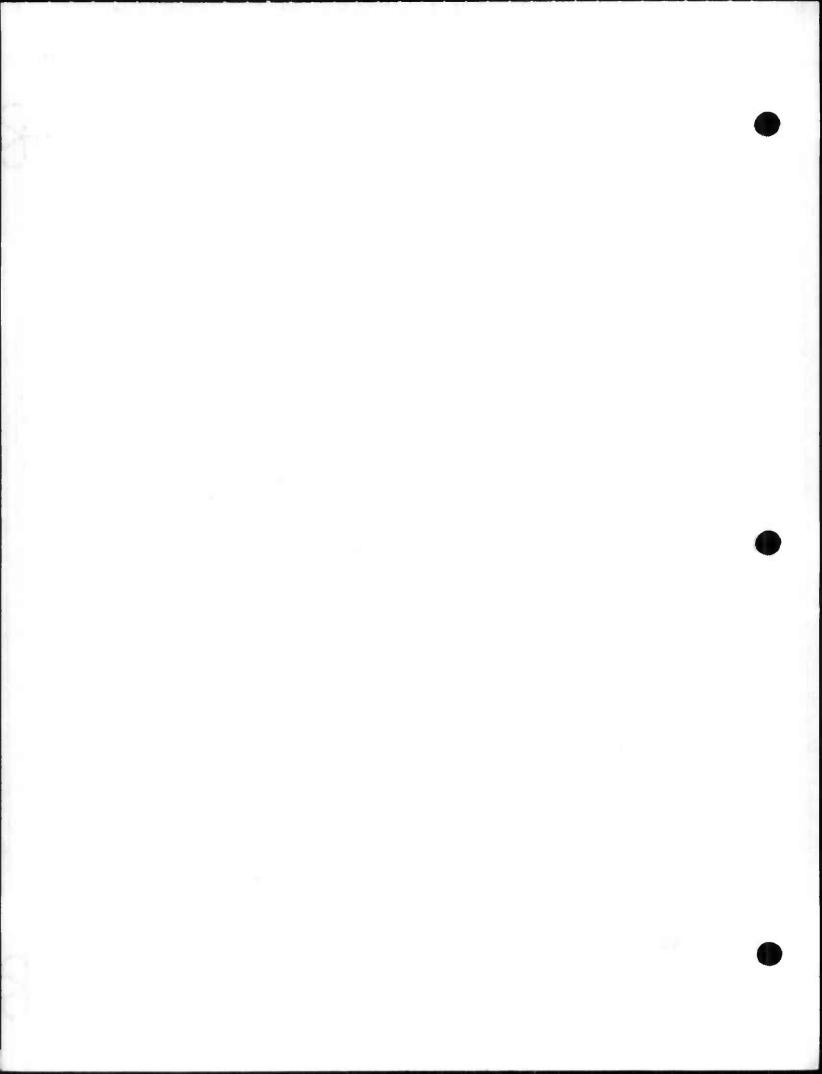
		1 - STATE REGISTRAR	SIATE OF I		/ DEPAR CERTIF					ENTAL HYGIEN REG. NO	_		
		1. DECEDENT'S NAME (First, Middle, Last)			Jeren III	IOAII	_ 01	DEA		2. DATE OF DEATH		3.	TIME OF DEATH
		Brian Douglas	Oberg							May 06,	1995	EAR	1455 p _M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	Country)	ACE (State or Foreign
pinous		215-90-1492 9a. FACILITY NAME (If not institution, give s		17	YRS.			- 220		(Month, Day, Year) Jan 10, 1			, D.C.
3 sho	Œ		l Hospit	2]		1			on of DEA deric		9c. COUNTY	of DEAT	
6,	CTOR	RESIDENCE OF DECEDENT	ir nospit	a.		FL	THEE	rre	deric	.K	Cas	vert	
r. Pages	DIRE	10a. STATE 10b. COUNT	Calver	t	10c. CIT	Y, TOWN (OR LOCAT	ION	Dunk	rirk			d. INSIDE CITY LIMITS?
Permi		10e. STREET AND NUMBER					101	ZIP CODE	E		10g. CITIZEI		T COUNTRY?
n. ansit	FUNERAL	11912 Riversh	ore Dr	ive					207	754	USA		
215-0020 attending physician. use as the burial-transit permit. Pages 1,	B	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 25			If yes, spi	city Cuba	OF HISPANIC on, Mexican, Specify:	ORIGIN? (Specify Ye Puerto Rican, atc.)	s or No 14	Black, W Specify:	American Indian, hite, stc.
	9	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a,	DECEDENT'S	USUAL O	CCUPATIO	N at of undia		16b. KIND OF BU	SINESS/INDUS		
21 21 10r	PLETI	Elementary/Secondary (0-12)	College (1-4 or 5	+)	tuder	se retired.)	auring mo:	st or workin	ng	high	schoo]	l	
AN the ho	once.	17. FATHER'S NAME (First, Middle, Last)					-	16. MOTH	HER'S NAM	E (First, Middle, Maiden	Surname)		
RYL M by	# III	Lawrence Alan	Oberg					Do	roth	ny Hele	n Ol	son	
MARYLAND retained by the hospit 5 should be detached	TO BE	190. INFORMANT'S NAME (Type/Print) Mrs. Dorothy H	Oborg		196. MAILING				or Rural Ro	ute Number, City or Tow	m, State, Zip Co	ide)	
	2	200. METHOD OF DISPOSITION	. Oberg		E AND DATE		-		DOVE	- T	CATION — City	on Town	Chan
ALTIMOR death. Page 6 ma funeral director, p	TS9E	1 Burial 2 Cremation 3 Rem	oval from State	cemetery,	Mem	ther place)	rde	ns	Mav	9,1995	Dunk		
TIN Page ral dir		21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE			- 1			SS OF FACI				,
BALTIMORE, its after death. Page 6 may be 1 by the funeral director, page removal.	examiner	> 4/1llean	X Th.		-	R	ausc	h Fu	inera.	l Home, P	.A., O	wing	s, MD
within 4 hours pletely filled in termation, or re-	event, the medical	23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications the List only one ceu	ise on each li	ne.					as cardiac or reap	iratory arrea	i i	Approximate Interval Between Onset and Death
P.O. BOX 68: th certificate be execute ending physician and o	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
DS, P the death the atten d Mental P		PART il. Other significent condition	a contributing to	deeth but no	t resulting	In the un	derlying	ceuse g	lven in P	ert i. 24e. WAS AN		24b. WE	RE AUTOPSY FINDINGS
RECOR equires that en signed by of Health an	MED	DID TORACCO USE CONT								PERFOI		CO OF	MPLETION OF CAUSE DEATH?
e law re has be Dept.	SICIAN	DID TOBACCO USE CONT	KIBUIE IO CA		ACE OF DEA			UNC	ERTAIN	Ш			
F VITAL SICIAN: The law certificate has the State Dept	SIC	EXAMINER?	HOSPITAL:			OTHER	₹:	. c □ 0.	nidoneo 8	Other (Specify)			
PHYSICIA This certifin with the	BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF (Month, D	INJURY	26b. TIM		28c. INJU	JRY AT	1	28d. DESCRIBE HOW I	NJURY OCCUR	ED	
SIC SIC TEND OR: A fter d		2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE O building,	F INJURY — At etc. (Specify)	home, term,	street, fact				Ret. LOCATION (Street City or Town, State)	and Number or	Rural Route	Number,
OR DIRI	COMPLET	29a. CERTIFIER (Check only one)	CIAN: To the best of	my knowledge,	death occurr	ed at the ti	me, date	and place,	and due to	the cause(s) and ma	nner an stated.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72	E CO	29b. SIGNATURE AND TOP OF CERTIFIER		xamination and/o	or investigation	on, in my o	pinion, de		ed at the tir				d manner as stated.
는 은 3 는 는 3 는 는 3 는 1	TO BE	ymath	5- A	5					395		▶ 5	16/	25
3		30. NAME AND ADDRESS OF PERSON WH Dr. Jonathan Fe	ars, M.D				ick						
		31. DATE FILED (Month, Day, Year)		R'S SIGNATURE		euer:	LCK	MG 20	0037			_	
		WAY 1 0 1995	Jun de	viction Ra	dall								



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH		HYGIENE REG. NO.
	2. DATE O	F DEATH

	1 - FOR STATE OF MARY	LAND / DEPARTI			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH		
	EDITH PEERCE				May 3.	1995	1:30 A M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AG	E (in yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign		
	216-18-7740 1□ м 2 🖫 🕫	91 YRS.	DAYS DAYS	HOURS MIN.	Jan. 18,		Country)		
	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY			
DIRECTOR	Magnolia Gardens Nursing Home Lanham Prince Ge								
3EC	10s. STATE 10b. COUNTY	10c. CITY, 1	TOWN OR LOCAT	ION			10d. INSIDE CITY		
	Maryland Prince George's	Lan	ham				LIMITS?		
AL	10s. STREET AND NUMBER		101.	ZIP CODE		10g. CITIZER	N OF WHAT COUNTRY?		
FUNERAL	8200 Goodluck Road		2	0706		U.S.A	A.		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED			IC ORIGIN? (Specify Yes	or No 14	. RACE — American Indian,		
BY F	1 Never Married 2 Married FORCES? 1 YE 3 Wildowed 4 Divorced IF YES, GIVE WAR OR		1 YES		n, Puerto Rican, atc.)		Black, White, etc. Specify:		
							White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US (Give kind of work	k done during mos		16b. KIND OF BUS	SINESS/INDUS	TRY		
E	Elementary/Secondary (0-12) College (1-4 or 5+)	ille. Do NOT use n	,						
M	6	Housewif	e		Own Ho				
ပ္ပ	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden	Surname)			
BE	John Irving				Carlisle				
ဝ	19a. INFORMANT'S NAME (Type/Print)				Route Number, City or Town				
	Isabelle Mary Schull				est Drive	#2106,	, Oakland Park,FL		
	20a. METHOD OF DISPOSITION 1 \times Burlat 2 \subseteq Cremation 3 \subseteq Removal Irom State	0b. PLACE AND DATE OF I emetery, crematory or other	DISPOSITION (Nat place)	ne of	DATE 20c. LO		y or Town, State		
H	4 Donation 5 Other (Specify)	emetery, cremetory or other Fort Lincol				ntwood	, Maryland		
	000		Franc	is Gasch	ts Sons Fu	neral	Home, P.A.		
	Mailes F. Bell of	_,					ille, MD 20781		
	23. PART i. Enter the diseases, or complications that caus	ed the death. Do not	entar the mod	fa of dying, auch	aa cardiac or reapi	ratory arreat	t, Approximata		
	ahock, or heart failure. List only one csusa on IMMEDIATE CAUSE (Final	each lina.					interval Batwean Onast and Death		
		cerch no vas	su Aac	a conde	L		2 weeks		
	DUE TO (OR AS	A CONSEQUENCE OF):	200,24	-000/00		-			
z	Anen	sclerofic	Vasulo	v disea	10		decades		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	A CONSEQUENCE OF):							
2	cause. Enter UNDERLYING CAUSE (Disease or injury								
H	that initiated events DUE TO (OR AS resulting in death) LAST	A CONSEQUENCE OF):							
ER	d.								
AL C	PART II. Other significant conditions contributing to death	but not resulting in t	tha underlying	cause given in	Part I. 24s, WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS		
S	Jenile dementra	•	,	g., a.,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ED					1 YES 2	NO	OF DEATH?		
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH VEC		LINICEDTAIN			1 TYES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH		UNCERTAIN	Ч Ш]				
200	EXAMINER? 1	0	THER!		and the second second				
¥	27. MANNER OP DEATH 28a. DATE OF INJURY			5 Residence	6 ☐ Other (Specify) 28d. DE\$CRIBE HOW II	N ILIBA OCCITO	OED.		
	1 Natural 5 Pending (Month, Day, Year) INJUR	Y WOI	ES 2 NO	200. DESCRIBE NOW II	NJORT OCCOR	60		
BY	2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJUI	RY — At home, Jarm, atre			281, LOCATION (Street a	and Mumber or I	Quant Davite Mumber		
	4 Homicide detarmined building, atc. (St	pecify)	and the order of the order		City or Town, State)	ING NUMBER OF R	nural House Number,		
COMPLETED	29a. CERTIFIER								
MP	(Check only 0 CERTIFYINO PHYSICIAN: To the best of my kno (no) 2 MEDICAL EVAMINED, On the best of appelled								
8	2 MEDICAL EXAMINER: On the basis of examinat	non and/or investigation, i	in my opinion, de	ath occured at the	Ilme, data and place, an	d dua to the co	ause(a) and manner as stated.		
H	296. SIGNOUNE AND TITLE OF REPUTER			29c. LICENSE NUM	90	29d. DATE SI	IGNED (Month, Day, Year)		
2	elly ghe luft			0227	200	5/	5795		
٦	30. NAME AND ABORESS OF PERSON WHO COMPLETED CAUSE OF I			D 4 "	100 =	, -	/		
			Center	Drive #	430, Green	belt,	MD 20770-3591		
	MAY U5 1995 Julia Savelson Range	GNATURE		-					
	MAY U5 1995 Julia Davidson Reve	tall							



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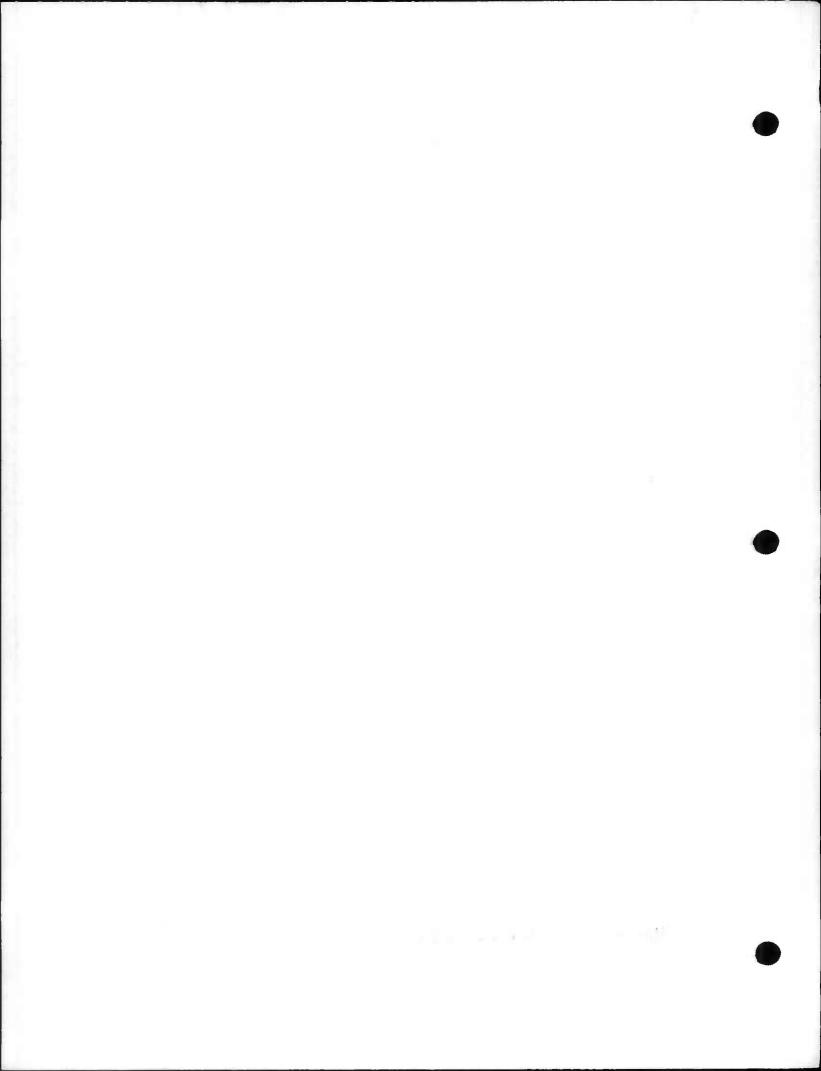
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhered hours after death. Page 6 may b	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR DWIGHT PARTELLO APRIL 1995 6:20PM REES 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS MIN. 578-03-0039 1 🔀 M 2 🗌 F 93 30, Nov. Washington, DC 1901 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George's Hospital Cheverly Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's College Heights Estates 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7002 Southwark Terrace 20740 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried 1 YES 2 X NO Specify: BY Specify: 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig College (1-4 or 5+) Elementary/Secondary (0-12) 12 Building Contractor Construction 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Dwight James Partello Augusta Evans Rees BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 James L. Partello 13801 Willoughby Road, Upper Marlboro, MD 20s. METHOD OF DISPOSITION
1 □ Burlai 2 ☑ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Metropolitan Crematory 4/29/95 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4 cesar 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List poly one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) AINOMIPHO RIGHT 400 W DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO FIBRILLATION ATRIAL COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 XHO OTHER: patient 2 - ER/Outpatie 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, tectory, office building, stc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED determined 29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 00/0 05 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6510 KENINGRITH MATHE W ANE 82. WEGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	DAI DIDETTO. After this confidence has been signed by the attending the six and commentative filled in the street discount of
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
		BERT	PER			2. DATE OF OEATH		95 5:30			
	579-30-2945	XX м 2 □ F (69 yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb 11,	1926	8. BIRTHPLACE (State or Fo Country) Washington	_		
TOR	90. FACILITY NAME (If not institution, give stree 5307 LORRAL RESIDENCE OF DECEDENT	NE DRIV	F	TEMP	OR LOCATION OF D			TY OF OEATH CE GEORGE	15		
DIRECTOR		George's		ry, town on loca emple Hi				10d. INSIDE CITY LIMITS? 1 YES 2			
FUNERAL	5307 Lorraine Dri			10	1. ZIP CODE 2074	18		en of what country? ed States			
BY	1 Never Merried 2 MMerried	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	If yes, ap		NIC ORIGIN? (Specify an, Puerto Rican, etc.) fy:	Yes or No-	14. RACE — American India Black, Whita, etc. Specify: White	ien,		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	TION pmpleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	usual occupati work done during me se retired.) 1 Surgeo	ost of working		BUSINESS/INDU	al Doctor)			
1 1	17. FATHER'S NAME (First, Middle, Last) Frank R. Perna					AME (First, Middle, Maid 7. Riley	len Surname)				
TO BE	190. INFORMANT'S NAME (Type/Print) Ellen S. Perna		196. MAILING 5307	A A A OORESS (Street of Lorraine	PRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Praine Drive, Temple Hills, Md 20748						
	20e_METHOD OF DISPOSITION 1 LABurlet 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)	Ma	PLACE AND DATE etery, cremetory or carry Land	Veterans	erme of May 5 Cemeter	Che	eltenha	m, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	NSEE	140					Home, Inc 66 nton, Md 207			
	23. PART I. Enter the diseases, or conshock, or heart failure. List IMMEDIATE CAUSE (Final	mplications that caused st only one cause on ea	the death. Do	not enter the mo	ode of dying, suc	ch as cardiac or re	spiratory arre	Approxime interval B	letween		
	disease or condition resulting in death) a.	Cardio-R	CONSTOUENCE O	Tory Ar	nest			Second	25		
CATION	Sequentially list conditions, if sny, leading to immediate	Cenebro - DUE TO (OR AS A	CONSEQUENCE O	DR AC	cident			minute	20		
MIF	cause, Enter UNDERLYING CAUSE (Disease or injury that Initiated events resulting in death) LAST	VA SCUL	R decide	NT	3 400	/					
SAL CE	PART II. Other significant conditions	contributing to death be	ut not resulting	in the underlyin	g cause given in	Part I. 24a. WAS	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FI AVAILABLE PRIOR			
: MEDIC	Hypertension					1 🗆 YES	2 X NO	COMPLETION OF COOP DEATH?			
PHYSICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			TH (Check only one)	UNCERTAI	N 🗆					
HASI	HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA OTHER: OTHER:							y) HOW INJURY OCCUREO			
D BY	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	- At home, term.	M 1 YES 2 NO			281. LOCATION (Street and Number or Rural Route Number,					
ETE	4 Homicide distermined City or Town, State)										
COMPL	(Check only one) 2 M. MEOICAL EXAMINER:	AN: To the best of my knowle On the besis of examination	edge, death occurr end/or investigation	ed at the time, date	end place, and due leath occured at the	to the cause(s) and not time, date and place,	end due to the	d. ceuse(e) end menner es s	stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER WILLSENGE M)			29c. LICENSE NU D 2 5 9		29d. DATE	SIGNED (Month, Day, Year)			
욘	J. RERGER MO (A)	COMPLETED CAUSE OF DEA	TTH (ITEM 27) (Type	Type, Print)				11/2001	,		

32. ABGISTRAFIS SIGNATURE
Julia d'involver Randoll

31. DATE FILEO (Month). Day, Year) 1995

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31. DATE FILED (Month, Day, Year)

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
OR	J.BE	OUL	E
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Fer MILTON APRIL 28 1995 1200 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Country) 2-3-46 218-44-7449 48 DAYS HOURS 1 M 2 - F YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10h COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. WORCESTER DCEAN CITY 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 21842 109. CITIZEN OF WHAT COUNTRY? 5 St. Louis Avenue 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. Never Married 2 Married BY Specify: 3 Widowed 4 Divorced WHITE 16a. DECEOENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EOUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind at work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5 +) MECHANIC SERVICE STATION 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN UNKNOWN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21842 THOMAS SNYDER PHILADELPHIA AVE., OCEAN CITY, MD., 20a. METHOD OF DISPOSITION
1 Burlal 2 Cremetion 3 Be 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) SALISBURY, MD SALISBURY CREMATORY 5 21. SIGNATURE OF FUNERAL SERVICE LICENSE ULLRICH FUNERAL HOME BERLIN, MD. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition_ Malignant Lymphoma resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 1 TYES 2 10 10 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Supperlient 2 ER/Outpetlent 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide detarmined 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 ___ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 030690 29 2 30/HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

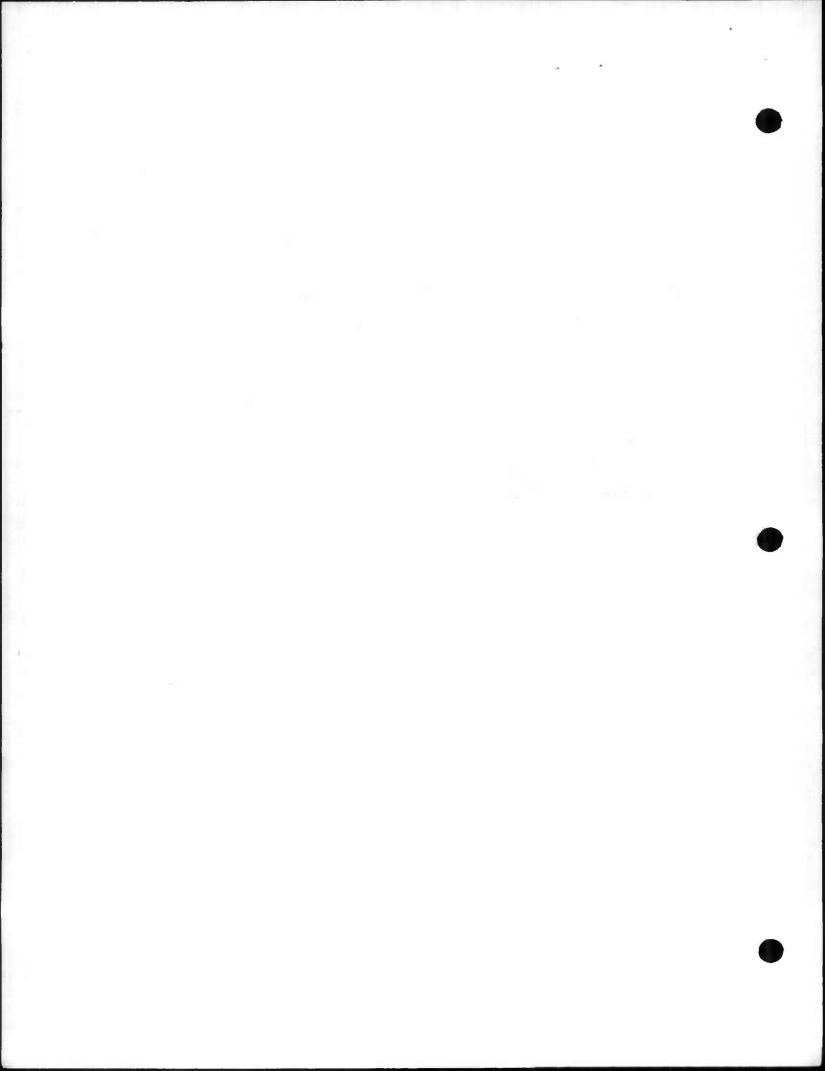
145 E. Carroll

32. REGISTRAR'S SIGNATURE

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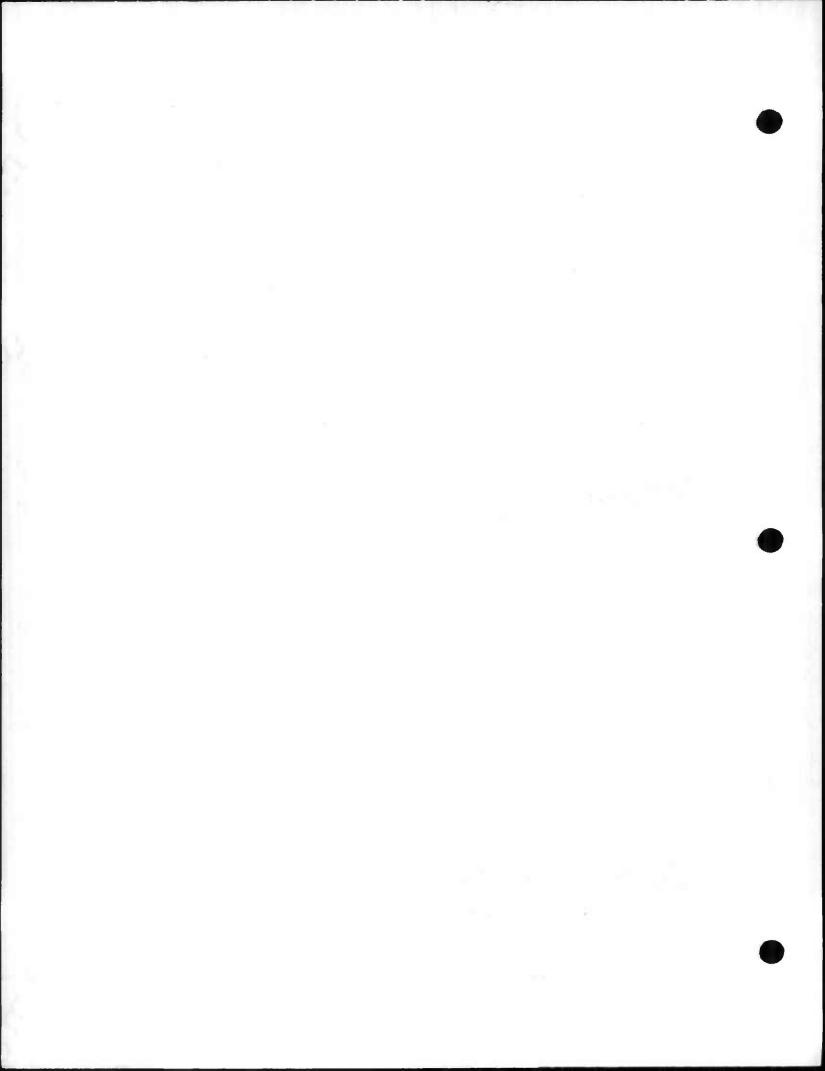
y physician. e burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mertal Hyghere prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

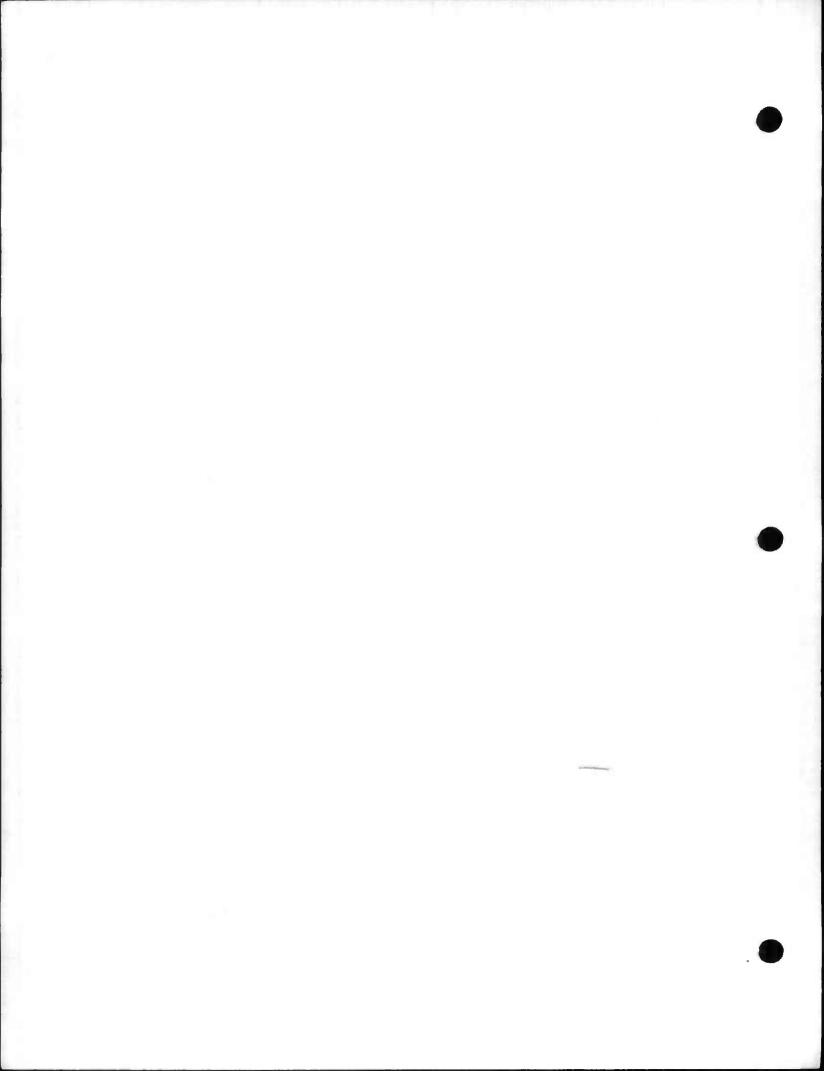
STATE OF	MARYLAND / DEPARTM	MENT OF HEALTH	AND I	MENTAL HYGIENE
	CERTIFIC	ATE OF DEA	TH	BEC NO

	1 - STATE REGISTRAR	STATE OF MA	ARTLAND /	ERTIF	TMENT	OF H	DEAT	AND	MENTAL	HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, Last,)					-			OF DEATH			3. TIME OF DEATH
	Walter Andrew Phillips May 11 1995												6:50A M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPI											PLACE (State or Foreign	
	144-12-8971	1 √M 2 □ F	70	YRS.	MONTHS	DAYS	HOURS	MIN.		1 2 1	925		, Jersev
_	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
DIRECTOR	2608 Point Lookout Cove Annapolis Anne Arundel												
D D	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CIT												104 INCIDE CITY
뜸											2.00	LIMITS?	
	4A- ATREET AND MINISTER										ZEN OF W	HAT COUNTRY?	
FUNERAL	2608 Point Lookout Cove 21401 United S											States	
3	11. MARITAL STATUS	12. WAS DECEDENT			13.	WAS DEC	ENDENT C	OF HISPA	NIC ORIGIN	(Specify Y		14. RACE	- American Indian,
BY F	1 Never Married 2 Kerried 3 Widowed 4 Divorced	FORCES? 1 S		NO			2 NO		n, Puerto F ly:	ican, etc.)		Specif	, White, etc.
		1943 -											White
13	15. DECEDENT'S EDI (Specify only highest grad	le completed)	, (G	CEDENT'S live kind of a Do NOT us	vork done o	during mo	ON st of workin	ng	16b.	KIND OF B	USINESS/IND	USTRY	
PLE	Elemantary/Secondary (6-12)	College (1-4 or 5+)		Polic		fice	r			Law	Enfo	rcem	ent
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							HER'S NA	ME (First, N				OTTE
l w	Thomas Phillips								na Ba		,		
0	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Number				wn, State, Zip	Code)	
5	Judith S. Phillip	S		2608	Poir	nt L	ooko	ut C	ove .	Annap	olis, l	Mary	land 21401
	20s. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 3 Har	noval from State	20b. PLACE			ITION (Na	me of		OATE	20c. L	OCATION —	City or To	wn, Stete
1 1	4 Donation 5 D Other (Specify)	-	Agin	gton	Nati	onal	Cen	nete	ry 5/	17/95	Arlin	gton,	Virginia
	21. SIGNATURE OF FUNERAL SERVICE L	CENGEE ()	//		22.	NAME AN	ID ADDRES	SS OF FA	Jol	n M.	Taylo	or Fu	uneral Home
	Denald x	1. Jun 7	or		1.	47 D	Duke	of (Glouc	ester	St. A	nnap	olis, MD
	23. PART I. Entar the diseeses, or abook, or heart failure	Complication that	coused the de	ath. Do n	ot enter	the mo	de of dyi	ing, suc	h aa card	ac or rea	piratory arr	est,	Approximate
	IMMEDIATE CAUSE (Final												
	disease or condition resulting in death) Cardio-Respiratory Failure												
	DUE TO (OR AS A CONSEQUENCE OF):												
፩	Sequentially list conditions, Due to (or as a consequence or):												
1 A	If any, leading to immediate cause. Enter UNDERLYING	*	l Cell			oma							į
Ē	CAUSE (Disease or injury that initiated events	<u> </u>	R AS A CONSE										
CERTIFICATION	resulting in desth) LAST	d	<u> </u>										
ادا	PART II. Other algnificent condition	ns contributing to de	ath but not r	eaulting i	n the un	derlying	ceuse c	lven in	Part i.	24a, WAS A	N AUTOPSY	246.	WERE AUTOPSY FINDINGS
2											RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC									_	1 YES	2 Dec		OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAU	SE OF DEA	TH YE	S \square N	10 🗆	UNC	ERTAII	N D				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	LIGORITAL .	26. PLAC	E OF DEAT									
VSI(1 - YES 2 - W	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER	t: iing Home	××.	sidence	6 Other	(Specify)			
	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,	JURY Year)	28b. TIM		28c. INJU	URY AT		28d. DES	RIBE HOW	INJURY OCC	URED	
1 N Netural 5 Pending (Month, Dey, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO								NO					
00	3 Suicide 6 Could not be 28. PLACE OF INJURY — Al home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number of Rural Rout								281. LOCA City o	TION (Street Town, State	end Number	or Rural Re	oute Number,
유	3 Suicide 6 Could not be 4 Homicide determined	building, etc	4 Homicide determined										
유	4 Homicide determined	building, etc						_	_				
유	4 Homicide determined 29e. CERTIFIER (Check only	BICIAN: To the best of m	/ knowledge, de	ath occurre	d at the ti	me, date	and place,	end due	to the caus	e(e) end mi	inner as state	ed.	
	29e. CERTIFIER (Check only one) 29 MEDICAL EXAMIN	SICIAN: To the best of m	y knowledge, de nination end/or i	ath occurre	d at the ti	me, date pinion, de	with occur	ed at the	ilme, dete	e(e) end mi	nner as state	ed. e cause(a)	and manner as stated.
BE COMPLETED	4 Homicide determined 29e. CERTIFIER (Check only	SICIAN: To the best of m	knowledge, de	ath occurre	d at the ti	me, date	29c. LICE	ed at the	ilme, date	e(e) and mi	29d. DATE	SIGNED	(Month, Day, Year)
COMPLETED	29e. CERTIFIER (Check only one) 29by SIGNATURE AND TITLE OF CENTIFIER AMAGE CONTROL FOR THE PLANT OF CONTROL FOR THE PLANT OF CENTIFIER AMAGE AMAGE CONTROL FOR THE PLANT OF CENTIFIER AMAGE CONTROL FOR THE PLANT OF CENTIFIER CONTROL FOR THE PLANT OF CENTIFIER AMAGE CONTROL FOR THE PLANT OF CENTIFIER AMAGE CONTROL FOR THE PLANT OF CENTIFIER AMAGE CONTROL FOR THE PLANT OF CENTIFIER CONTROL F	SICIAN: To the best of m	ninetion end/or	Investigation	n, In my o	me, dete	29c. LICE	ed at the	ilme, dete	e(a) and maind place, a	29d. DATE	SIGNED	
BE COMPLETED	29e. CERTIFIER (Check only one) 29by SIGNATURE AND TITLE OF CENTIFIE 30. NAME AND ADDRESS OF PERSON WITH	SICIAN: To the best of my ER: On the best of exam	of DEATH (ITEI	M 27) (Type,	n, In my o	pinion, de	29c. LICE	ed at the	HIME, dete	e(a) and ma	29d. DATE	SIGNED	(Month, Day, Year)
BE COMPLETED	29e. CERTIFIER (Check only one) 29by SIGNATURE AND TITLE OF CENTIFIER AMAGE CONTROL FOR THE PROPERTY OF THE	SICIAN: To the best of my ER: On the best of exam	of DEATH (ITEE	M 27) (Type,	n, In my o	pinion, de	29c. LICE	ed at the	HIME, dete	e(a) and mi	29d. DATE	SIGNED	(Month, Day, Year)



FOR STATE ST

			1 - REGISTRAR			ERTIF	ICATE	OF	DEATH	REG. N	0.		
			1. DECEDENT'S NAME (First, Middle, Last)						· ·	2. DATE OF DEATH MONTH DAY YEAR			3. TIME OF DEATH
			HASTUBAL ARMANDO			PAZ					95	8:20P M	
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 Y		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHP	LACE (State or Foreign
,	. I		N/A	1 🖳 M 2 🗆 F		YRS.	MONTHS D	3	HOURS MIN.	January 2	4.	Mar Mar	yland
	2, 3 should	OR	90. FACILITY NAME (If not institution, give holy cross ho	spital			96. CITY, TO Sil	Lve	r LOCATION OF DI	ng		INTY OF DE	
		5	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT	~		T							
	2	DIRECTOR		gomery			y, town on i eaton	LOCATI	ON			- 1	IOd. INSIDE CITY LIMITS? I YES 2X NO
	E E	A	10e. STREET AND NUMBER	Aomez y		1 1111	cacon	101.	ZIP CODE		10g. CIT		IAT COUNTRY?
an.	bunal-transit permit. Pages 1,	FUNERAL	11500 Amherst Ave			- 6			20902			U.S.A	
9 8	e e	BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT FORCES? 1 IF YES, GIVE WI	YES 2T		If ye	YES			es or No—	Black, Specify:	
215 attend	nse as	ETED	15. OECEDENT'S EDU (Specify only highest grade	CATION	16a. I	DECEOENT'S	USUAL OCCL	JPATIO	٧	16b. KIND OF B	USINESS/INI	Whi	ce
CA 18	Ď.		Elementary/Secondary (0-12)	College (1-4 or 5+)	- 4	lle. Do NOT u	work done duri se retired.)	ng mos	t of working				
Nosp	Se acried	COMPL	N/A			N/A				N/A			
MARYLAND 2	at once.		17. FATHER'S NAME (First, Middle, Last)	_						ME (First, Middle, Maide	,		
ARY ned b		H	Pedro Armando Pa	Z		ION MAILING	ADDRESS /S		-	oxana Her			
		2	Pedro Armando Pa	7						#101 Whea			nd 20002
AE,	must be r		20a. METHOD OF DISPOSITION				OF DISPOSITIO					City or Town	
10	OF TOP		1 🕮 Burlai 2 🗆 Cremation 3 🗆 Ren 4 🗆 Donation 5 🗆 Other (Specify)	noval from Stata	Gate	of H	ther plece) eaven	Cen	netery	5/1/95Sil			,
TIN Page	examiner		21. SIGNATURE OF FUNERAL SERVICE LI	PENSEE			22. NAI	WE AND	ADDRESS OF FA	CILITY			
AL	exan		* (telegral)	tional						lins Fune y Blvd.,W			
after CB	S E 3		23. PART I. Enter the disesses, or	complications that	caused the	death. Do r	not enter the	e mod	e of dying, suc	h ss cardisc or ree	piratory sn	rest,	Approximate
24 hours	ÖE		shock, or heart failure. IMMEDIATE CAUSE (Final	List only one caus	e on each li	ne.							Interval Between Onset and Death
	cremation,	ļ	disease or condition resulting in death)	SUDDEN 1	INFANT D	EATH SY	NDROME						
60 with	al, cremati event, t		Toballing in addition	DUE TO (OR AS A CONS	EQUENCE O	F):						
9 9 5	Hygiene prior to burial, cremation, or other traumatic event, the	S	Sequentially list conditions,	b									
BOX	rior to	ERTIFICATION	If sny, leading to immediate csuse. Enter UNDERLYING	001 10 (OR AS A CONS	EQUENCE O	F):						
O. B.	mal Hygiene prior to y, or other traun	읦	CAUSE (Diseese or Injury thet initiated events	DUE TO (OR AS A CONS	EQUENCE O	F):				-		
P.O	5 b		reaulting in deeth) LAST	d									
DS, P	Mental Mental	O	PART II. Other significent condition	na contributing to d	leath but not	regulting	in the under	elvina	cause alven in	Part I at uno a	N AUTOPSY	Tan n	
~ = 3	- 8	DICAL			acotti bat not	leediting	in the dilge	riying	cease given in	PERFO	PRMED?	A	PERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
RECC requires t										1 XYES	2 NO	C	F DEATH?
N requi	t. of Heal	PHYSICIAN: ME	DID TOBACCO USE CONT	RIBUTE TO CAL	ISE OF DE	ATH YE	SINO		UNCERTAIN			1	YES 2 - NO
- 6	2 2	¥	25. WAS CASE REFERRED TO MEDICAL	The CAC			H (Check only		OITCERIAII	4 🗆 📗		-	
F VIT	State	Sic	EXAMINER?	HOSPITAL:	M/Outpatient	3 DOA	OTHER:	Home	5 Residence	8 Other (Specify)			
OF PHYSICIA	with the	美	27. MANNER OF OEATH	28a. DATE OF II (Month, Day	NJURY	28b. TIM		c. INJU	RY AT	28d. DESCRIBE HOW	INJURY OC	CURED	
O N		BY	1 Netural 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, roury			WOR YE	S 2 NO				
N N N N	is in		3 Suicide a Could not be	28s. PLACE OF building, s	INJURY — At I	nome, ferm, s	treet, factory,	office		28f. LOCATION (Street City or Town, State	and Number	or Rural Rou	rte Number,
VIS	n 28 i		4 Homicide determined							ony or rown, order			
DI DIR	2 hours	3	29a. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the best of n	ny knowledge, d	leath occurre	d at the time,	dats a	nd place, and due	fo the cause(s) and m	enner se stat	ted.	
THE HOSPITAL	NT: D	COMPLET	one) 2 MEDICAL EXAMINE	R: On the beals of axe	mination and/o	r investigatio	n, in my opini	on, de	ith occured at the	time, data and place, a	nd due to th	na cause(s) a	ind manner as stated.
H H	DRTA WIT	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	- 1 11				\top	29c. LICENSE NUN	IBER	29d. DAT	E SIGNED (A	fonth, Day, Year)
5 5	be filed within 72 h	2	Denn	//	utems				0.C.	M.E.	▶ P	APRIL	28/95
		-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE									
			21 DATE EN ED (Month Day Word	An project	T T T]	ENN	STRE	ET,	BALTI	MORE, MA	ARYLA	AND 2	1201
			31. DATE FILED (Month, Day, Year) MAY 02 1995	Julia d'auc	Sor hard	all							

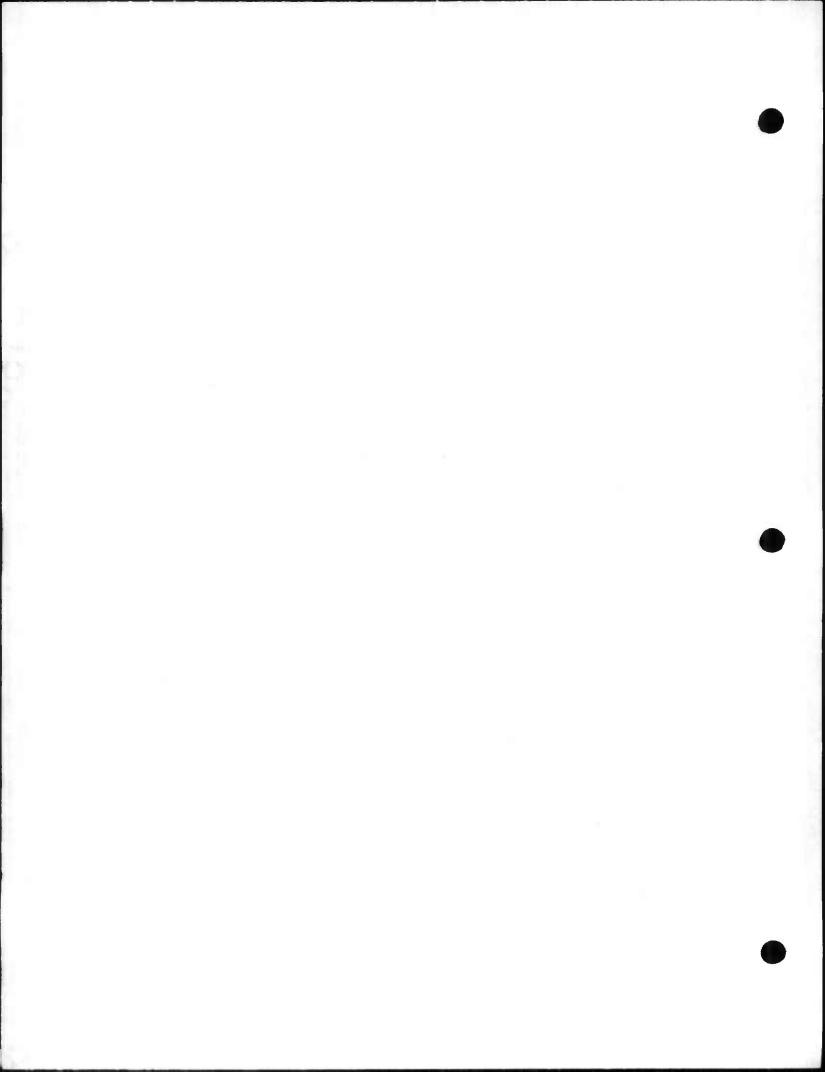


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CIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	inflicate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
requires that the dea	of Health and Ments	shows any injury,
CIAN: The law	ertificate has b	or Item 23
ATTENDING PHYSIC	R: After this co	tem 28 is marked,
HOSPITAL OR	FUNERAL DIRECTO within 72 hours aft	TANT: If item
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HELEN APRIL 1995 B PETERS 11:10 pm A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign April 9, 89 HOURS 578-12-1762 1 - M 2 XF Ohio YRS 1906 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Washington, D.C. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 220 Whittier St. NW 20012 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 200 NO 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES NO ☐ Never Married 2 ☐ Married 1 TES 2 NO В 3.XWidowed 4 Divorced Specify: Specify: white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) 12 College (1-4 or 5+) clerk U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME /First Middle Meiden Sumame unobtainable BE unobtainable 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward G. Winner 219 Whittier St. NW Washington, D.C. 20012 20s. METHOD OF DISPOSITION
1 X Buriel 2 Cremation 3 R 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1X Buriel 2 Cremation 3 4 Donation 5 Other (Specify). Ft. Lincoln Cemetery May 2,1995 Brentwood, MD 22. NAME AND ADDRESS OF FACILITY
Takoma Funeral Home, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE sup 254 Carroll St. NW Washington, D.C. 20012 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line. Approximata Interval Bety IMMEDIATE CAUSE (Final **Onset and Death** disease or condition ASSIRATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not recuiting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO ВУ 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. Could not be 4 Homicide determined 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the cause(e) and manner ee stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner ee stated, 29b. SIGNATURE AND PITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 3

0 27 1995 2 30. NAME AND ADDRESS OF PERSON WAO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 76-FFFEY 6525 BELLREST EIMAN 31. DATE/FILED (Month, Day, Joar) 32. REGISTRAP'S SIGNATURE 02 1995 DHMH-16 Rev 1/89



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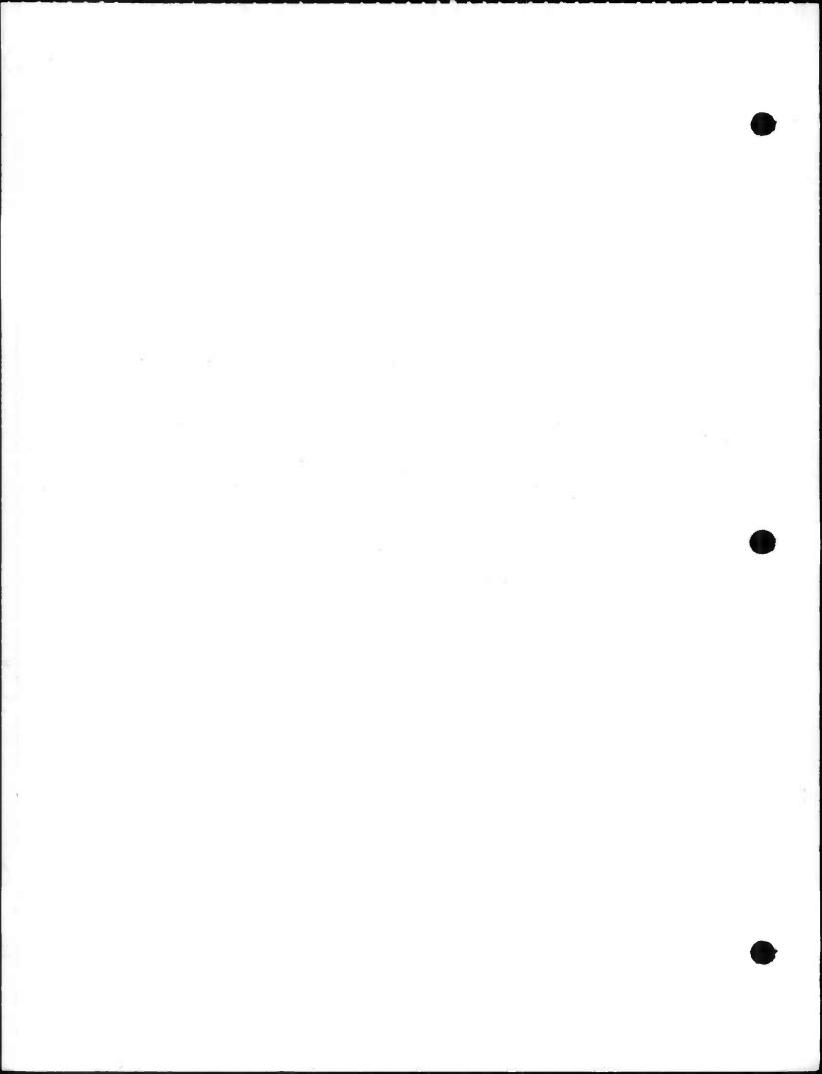
DIVISION OF VITAL RECORDS, P.O. BO

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burlat, creating remainer must be marked at page 6. It marked on them 23 shows any litter or other trainmails event the marked as marked or them 23 shows any litter or other trainmails event the marked.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	Middle Leet				IOAIL			1	HEG. NO.			
	,	, moon, Lesty								2. DATE OF OEATH MONTH DAY YEAR			3. TIME OF DEATN
	Ruby	T			iddy				_		995		12:30 A M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yr	s. last birthday)	MONTHS 1		IF UNDER 24 HRS		ATE OF BIRTH Month, Day, Year)		8. BIRTH Counti	IPLACE (State or Foreign
	408-36-5734		1 - M 2 - F	100	YRS.	MONTHS	UATS H	TOURS MIN.		ay 9, 18	94		sissippi
	9e. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					4 4		
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1 %	4750 Chevy	CHASE	Dilve, f	1212			nevy	Chase			Mo	ntgo	mery
DIRECTOR	10a. STATE	10b. COUNT			10c. C/1	Y, TOWH OF	LOCATION	N.					10d. INSIDE CITY
1 %	Maryland	Mon	tgomery			Chor	y Ch	300					LIMITS?
	10e. STREET AND NUMBER		egomery			CIICV		IP CODE			40 0/2		
N W	1750 Charm Chara Daine #31						101. 2.1				iog. Ci i	IZEN OF V	WHAT COUNTRY?
N N	4750 Chevy Chase Drive, #21							20815				ited	States
FUNERAL	1 Never Married 2	Married	12. WAS OECEDEN FORCES? 1							RIGIN? (Specify Year orto Rican, etc.)	or No-	14. RACE Black	E — American Indian, k, White, etc.
B⊀	3 N Widowed 4 Divo		IF YES, GIVE W	AR OR DATES	S			NO Spe		, , , , , , , , , , , , , , , , , , , ,		Speci	
			1										White
<u> </u>		EDENT'S EDU		164	 DECEDENT'S (Give kind of 	work done di	CUPATION uring most of	of working		16b. KIND OF BUS	INESS/INC	DUSTRY	
iu iu	Elementary/Secondary (0	1-12)	College (1-4 or 5 +	+)	Iffe. Do NOT u	se retired.)			- 1	Air F	orce		
4 D			2		Sup	ply C	lerk			Suppl	y De	pot	
COMPLETED	17. FATNER'S NAME (First, M	liddle, Last)					1	IS. MOTNER'S	NAME (F)	irst, Middle, Malden	Surname)		
BE	Joseph Ma.	lcolm	Tucker					Emma	Ric	hards			
	19e. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	AOORESS	(Street and			Number, City or Town	State 7ir	Codel	2224
2	Barbara C.	Pridd	V										20815
5	20a, METHOD OF DISPOSIT		<u> </u>	1						#212, C			
i i	1 🕅 Burlel 2 🗌 Cremetic	n 3 🗆 Rem	oval from State	cemeter	ACE AND DATE y, crematory or o	ther place)			1		CATION —	•	
	4 Donation 5 Other			Memo	orial 1	Park		May 8,		95 Mem	phis,	, Ter	nnessee
Tentil Indiana	21. SIGNATURE OF FUNERAL SERVICE LICENSEE MOORS 1 22. NAME AND ADDRESS OF FACILITY RODERT A. PUMP Preval Home										/		
	ROBERT A. Pumphrey Funeral Home/ Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501												
	Avenue, Bethesda, Maryland 20814-3501 23. PART I. Enter the discessa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete												
	shock, or h	aert fallure.	List only one cau	se on eech	e death, Do i lina,	not enter t	he moda	of dying, s	ich ss	cardlec or respi	ratory ar	reat,	Approximete interval Between
	IMMEDIATE CAUSE (Fir	nel											Onset and Death
	disesse or condition	→	Respi	ratory	arres	t							
	resulting in desth) Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF):												
z					rophy								
NOI	Sequentially list conditions if any leading to imme	lone,	. Cerebi	ral At	rophy								
CATION	if any, leeding to immed cause. Enter UNDERLY	diste ING	. Cerebi	ral At									
FICATION	if any, leeding to immed cause. Enter UNDERLY! CAUSE (Disease or Inju	diste ING	b. Cerebi DUE TO	ral At		F):							
RTIFICATION	if any, leeding to immed cause. Enter UNDERLY	diste ING Iry	b. Cerebi DUE TO	ral At	NSEOŪENĆE O	F):							
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AL CERTIFICATION	if any, leeding to immer cause. Enter UNDERLY! CAUSE (Disesse or inju- that initiated events	diste ING IT	c. Cerebi	ral At (OR AS A COI	NSEQUENCE O	F):	lerlying c	ceuse givan	n Part	1. 24s. WAS AN		24b.	. WERE AUTOPSY FINDINGS
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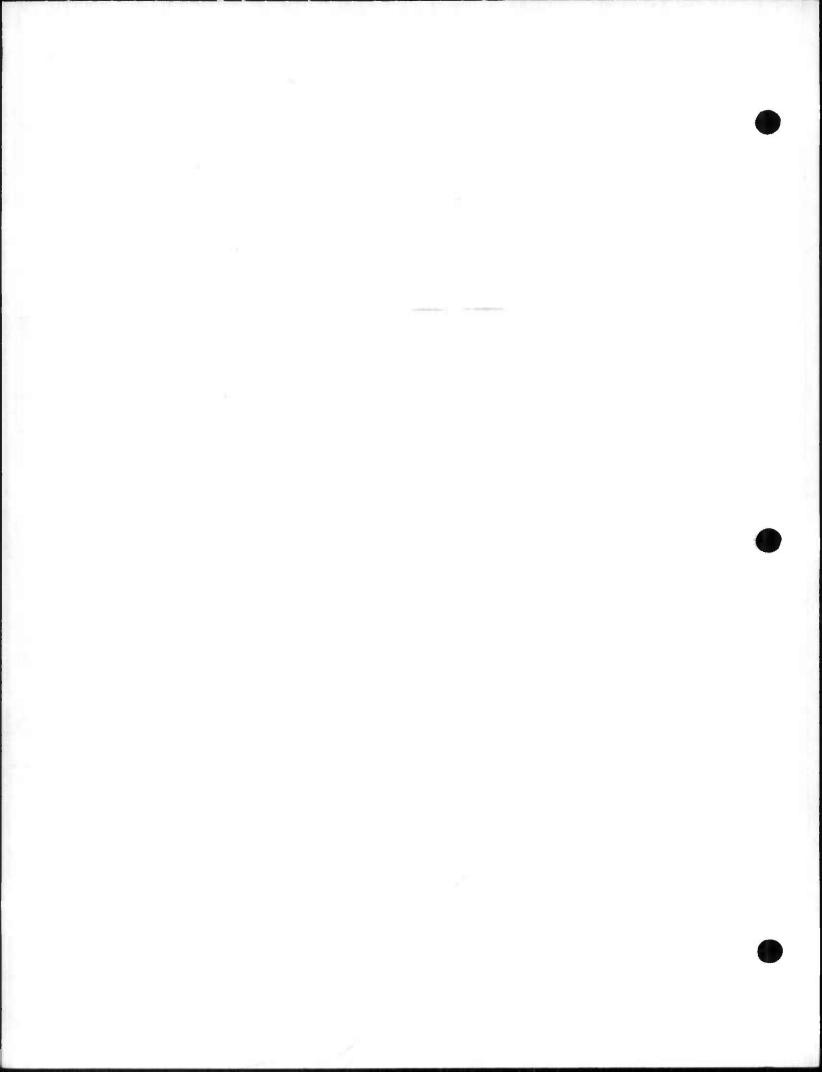
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

		CTATE	OF	18.6	DVI	AMD	,	DEPARTMENT	OF.
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STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	łΕ
		CE	ERTIFICATE	OI	F DEAT	H		REG NO	

	1 - FOR STATE REGISTRAR	STATE OF 1	MARYLAND /	DEPAR	RIMENT OF	HEALTH AND	MENTA	HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH			3. TIME OF DEATH
	Kent K	ane	Pa	rrot			Apr	1 28,	1995	YEAR	1:12 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BURTH		6. BIRTH	PLACE (State or Foreign
	559-18-4943	1 🖾 M 2 🗌 F	83	YRS.	MONTHS DAYS	HOURS MIN.	Jun	Day, Your) 9	11	Countr	lif.
_							9c. COUNT	NTY OF DEATH			
E						hesda				gome	ery
DIRECTOR	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNT	TY		10c. CIT	Y. TOWN OR LOC	, TOWN OR LOCATION					464 MOIDE OFF
l E	Maryland Mont	gomery			vy Chas						10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	Bomery		One		Of, ZIP CODE			100 CITIZ	EN OF W	1 X YES 2 NO
ER/	5506 Grove Street 20815							S.A.			
FUNERAL	11. MARITAL STATUS		IT EVER IN U.S. AF		13. WAS DI	CENDENT OF HISPA	ANIC ORIGIN	? (Specify Yes			
	1 Never Married 2 Married	FORCES? 1	YES 2 □ I	NO 42_191	If you	pecify Cuban, Mexic	cen, Puerto F	lican, etc.)		Specif	- Americen Indien, White, etc.
BY	3 Widowed 4 Divorced	196					,			whi	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad	UCATION le completed)	18a. DE	CEDENT'S	WORK done during in se retired.)	ION ost of working	16b.	KIND OF BUS	SINESS/INDU	STRY	
19	Elementary/Secondary (0-12)	College (1-4 or 5	-) [
₩.		5+	P	ublis	sher			rinti		npan	У
	17. FATHER'S NAME (First, Middle, Last) Kent K		D			18. MOTHER'S N	IAME (First, A				
86	184, INFORMANT'S NAME (Type/Print)		Parr	_		Mary			Alsop		
2	Deirdre Parrot					and Number or Rura	l Route Numb	er, City or Town	n, State, Zip C	Code)	
				-	as #10			_			
ш	20s. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremetion 3 □ Ran	noval from State	cemetery, cre	and DATE	OF DISPOSITION (I	lame of	DATE	20c. LO	CATION — CI	ty or To	wn, State
ш	commettery cremetery or other place Metropolitan Crematory May1,1995 Alex., Va. 22. NAME AND ADDRESS OF FACILITY										
	1 0	190111	()			IND ADDRESS OF F	D	eVol 1	Funera	11 H	ome
\vdash	ames a	D NOT			2222	Wisc. Av	re., N	.W., V	Wash.	D.C	. 20007
Ш	23, PART LEnter the diseases, or shock, or hasrt fallure.	complications the	t caused the de	eth. Do	not enter the m	ode of dying, su	ch aa cerd	lec or respi	ratory arre	at,	Approximats Interval Between
П	IMMEDIATE CAUSE (Finel	,,									Onset and Death
	disease or condition resulting in deeth)	Intra	acranial	Hem	morrhage	1					7 hours
	DUE TO (OR AS A CONSEQUENCE OF):										
8	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	If any, leading to immediate cause, Enter UNDERLYING	DUE TO	(OR AS A CONSE	OUENCE O	F):						
윤	CAUSE (Disease or Injury	c	(OR AS A CONSEC	DIJENCE O	D:						
Ē	that initieted eventa resulting in dasth) LAST		(on no h oonoe	OCCITOR O	.,.						
핑		d									
귛	PART II. Other significant condition	ns contributing to	deeth but not r	resulting	in the underlyl	ig ceuse given li	n Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC	<u>hypertension</u>							1 YES 2			COMPLETION OF CAUSE OF DEATH?
ME											1 TYES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S NO [UNCERTA	IN 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26, PLAC	E OF DEA	TH (Check only one						
YSI	1 YES 2 NO	1 2 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Ho	ne 5 🗆 Residence	6 🗆 Other	(Specify)			
H	27. MANNER OF DEATH 1 K Netural 5 Pending	28a. DATE OF (Month, D		28b. TIM INJ		JURY AT ORK?	28d. DE\$	CRIBE HOW IF	NJURY OCCU	RED	
₽	1 K Netural 5 Pending 2 Accident Investigation					YES 2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm, :	street, factory, off	ia .	28f. LOCA City o	TION (Street e	nd Number of	r Aural A	oute Number,
E I											
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYINO PHYS										
O.	one) 2 MEDICAL EXAMIN	ER: On the basis of ea	camination and/or i	Investigatio	on, in my opinion,	death occured at the	e time, date	and place, and	d due to the	cause(s)	and manner es stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	R		-		29c. LICENSE NU	JMBER		29d, DATE	SIGNED	(Month, Day, Year)
TO B		Valel				D0649	3		▶ Apr	ril	28,1995
=	30. NAME AND ADDRESS OF PERSON WH										
	Lawrence(Wildw) Widerli	te, M.D.	.,540)1 Weste	rn Ave.,	N.W.,	Wash.,	D.C.	200	16
	31. DATE FILED (MONTH, Day, Year) MAY 04 1995	3. REGISTRA	R'S SIGNATURE	211							
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1622

32 REGISTRAR'S SIGNATURE
Fulla Davidson hardall

MD

APR 1 8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Henry Perkins 5:10 PM April 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIFTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Fo. Country) 6 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH C. COUNTY OF DEAT Wicomico Nursing Home DIRECTOR Salisbury Wicomico RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BuitlANA W108 M166 1 YES 2 WHE 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 00 AVE funeral director, page 5 should be detached for use as the burial-transit 21826 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 TYES 2 THOUSE IF YES, GIYE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Nover Merried 2 Merried If yee, specify Cuben, Mexicent, Puerto Rican, etc.) В 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) LABOL AKMIN 17. FATHER'S NAME (First, Migdle, Last) 18. MOTHER'S NAME (First, Middle NOCOLA F UNENOW BE 190 INFORMANT'S NAME (Type 19b. MAILING ADDRESS 9 8102 ORCRSTEL Md, 218/1 9 20e. METHOD OF DISPOSITION
1 Burlel 2 Cremetton 3 Rec 20b. PLACE AND DATE OF DISPOSITION (No must Emetery, crematory or other place Md 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICES 15ABRUA SHIBUR the attending physician and completely filled in by the it Mental Hygiene prior to burial, cremation, or removal. event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata ahock, or heart failure. List only one ceuse on each line. al Between IMMEDIATE CAUSE (Final Onset and Death Metastatic Disease To Bone and Liver 61 Months resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) the death certificate be executed traumatic Cancer of the Prostate
DUE TO (DR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, Years If any, leeding to immediate cause. Entar UNDERLYING Liver Failure
DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury or other that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO been signed by th any COMPLETION OF CAUSE 1 TES 2 X NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) this certificate h HOSPITAL OTHER: 1 TES 2 XNO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 4 X Nurs Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO DIRECTOR: After the hours after death v BY 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Spec/ly) 3 Sulcide 60 COMPLETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 | Homicide 28 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee atated. TO THE HOSPITAL OF THE FUNERAL DE FINE WITHIN 72 M (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ea stated. 298L SIGNATURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

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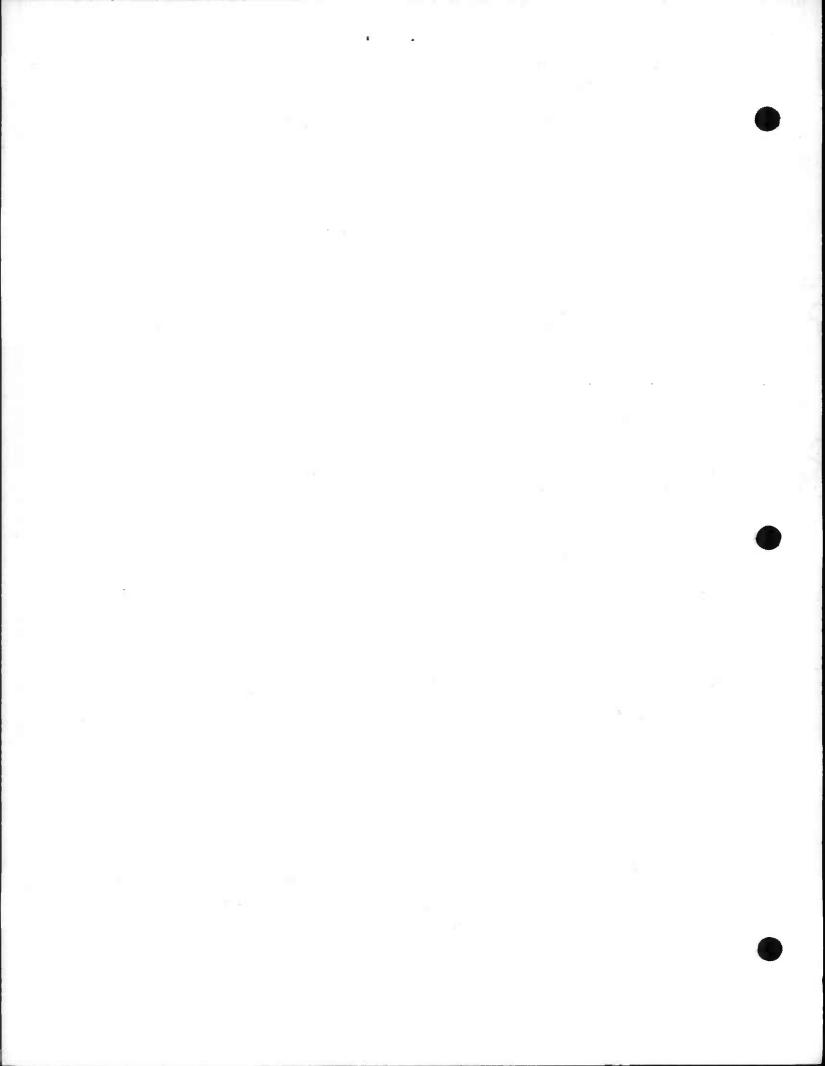
Amended # 1, 4-17-95

1 - STATE BJV, Talbot Co STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OLIVER Price 04 -4-15771 5. SEX 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 | F 161-20-4872 YRS. MARYLAND permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 8127 SALT LAKE DRIVE BALTIMORE BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? retained by the hospital or attending physician. 5 should be detached for use as the burial-transit 8127 SALT LAKE DRIVE 21207 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2XXNO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 6th LABORER SEAFOOD PLANT once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surnam notified at OSCAR B. PRICE BE KATIE ELIZABETH PRITCHETT 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARY GREENE Page 6 may be KINSEY ST., PHILADEPHIA, PA., 19124 must be 20s. METHOD OF DISPOSITION

1 Spuriel 2 Cremetion 3 Removal from State
4 Donatton 6 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ROBINSON A.M.E. CEM. APR. 15,95 GRASONVILLE, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BENNIE SMITH FUNERAL SERVICES BOX 1687, EASTON, MD. 21601 completely filled in by the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** 12 primary, 2nd primary shock, or heart failure. List only one causa on each lina. Interval Between 0 IMMEDIATE CAUSE (Final Onset and Death 計 disease or condition larchoma, gloth's a. Squamous cell
DUE TO (OR AS A CONSEC resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): hysician and com prior to burial, (yrs CERTIFICATION Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY and the shows any Health a 1 TYES 2 NO OF DEATH? been s 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCUREO marked, 1 X Natural NA 1 YES 2 NO After death BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 COMPLETED 8 Could not be DIRECTOR: after 28 4 Homicide determined hours 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(e) end manner as stated. TO THE HOSPITAL ITO THE FUNERAL IS BE filed within 72 h MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piecs, and due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D46331 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print) G. Scottlong, analogy Center Johns Hydring Highel Good Newalfest Boltomore NO 21227

32. REGISTRAR'S SIGNATURE RONALLY



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DIVI	ON STATEMENT PRINCIPLES. THE STATEMENT OF THE STATEMENT O

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	Jennie Olive Prid	ce				May 2. 1	1995	1540 hrs M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign			
	221-16-1898	1 □ M 2 ☒ F 9	6 YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) September 18,	, 1898 Mai	ryland			
	9a. FACILITY NAME (If not institution, give s		1	b. CITY, TOWN C	R LOCATION OF DE		9c. COUNTY OF C	2			
OH	Laurelwood Nursir	ng Home		Elk	tton		Ceci]				
<u> </u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y	10c, CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY			
DIRECTOR	Maryland Cecil Cecilton										
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF	1 X YES 2 □ NO WHAT COUNTRY?			
FUNERAL	250 West Main Str	reet		2	21913		United	States			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IF FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yea	or No 14. RAC	E — American Indian, k, Whita, atc.			
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D.			2 X NO Specify	n, Puarto Rican, etc.)	Spec	ity:			
	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S US	NIAL COCURATIO				nite			
	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind of wor	k done during ma	st of working	16b. KIND OF BUS	SINESS/INOUSTRY				
IPL	7	College (1-4 or 5+)	Homemake	r		Domes	stic / Ov	m Home			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden		III IIOME			
BE	Alfred Craig				Ellen	Bailey					
TO E	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town	, , , , , , , , , , , , , , , , , , , ,				
	Geraldine Miller		122 Ea	st Main	Street,	Cecilton,	Marylar	d 21913			
	20a, METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Agency)										
	1XX Surial 2 Cremetion 3 Removal from Stata Cemetery cremetory or other place Cecilton Zion Cemetery May 6, 1995 Cecilton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
		1	fall			al Homes,	P.A.				
_	William L. K		d Amy	226 Eas	st Main St	reet. Cecilto	n. Marvlan	d 21913			
	23. PART i. Enter the diseeses, or cahock, or heert fallure.	complications that cause on a	the deeth Do not	enter the mo	de of dying, suci	h es cerdiac or respi	retory arrest,	Approximate interval Between			
	IMMEDIATE CAUSE (Fine)	<u>-</u> 1	. Reval	(-1)			Onset and Death			
	resulting in death)	DUE TO (OR AS 4	CONSEQUENCE OF:	ran	line		Say				
_	_	C.44	-					Mentho			
2	Sequentially liet conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF):					7.04.00			
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	a Arter	iscleral	ic con	anany	artery di	seare	Years			
E	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):		J						
CERTIFICATION	resulting in death) CAST	d									
AL C	PART li. Other aignificent condition	e contributing to deeth b	ut not resulting in	the underlying	cause given in	Part i. 24s. WAS AN		. WERE AUTOPSY FINDINGS			
2	Samentia					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ME								OF DEATH? 1 YES 2 NO			
ž	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	1 🗆					
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF OEATH	(Check only one)							
ΙΧ	1 YES 2 NO	1 Inpatient 2 ER/Outp	atient 3 DOA 4	☐ Nursing Home		8 Other (Specify)					
	27. MANNER OF DEATH t Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO	RK?	28d. DEŞCRIBE HOW IN	JURY OCCURED				
B√	2 Accident Investigation	28a. PLACE OF INJURY	At home form stor		ES 2 NO	201 LOOKED (C)					
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spec	ify)	ret, tectory, offica		28f. LOCATION (Street a City or Town, State)	nd Number or Hural i	Houte Number,			
9	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN To the best of the		SECTIONS:	ACTA (On Notice)						
MP		CIAN: To the best of my knowl R: On the besis of examination						Name			
8	Ben	the A			B302		29d, DATE SIGNED	gronth, Day, Year)			
유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF OE	ATH (ITEM 27) (Type, Pr	int)			3/0/				
	R. Denitzio.	Rt. 213 (recilto.	J. Mi	D. 219	1.3					
, 1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN.	ATURE								
T	MAY 0 5 '95	gua vardson-1	jandell								

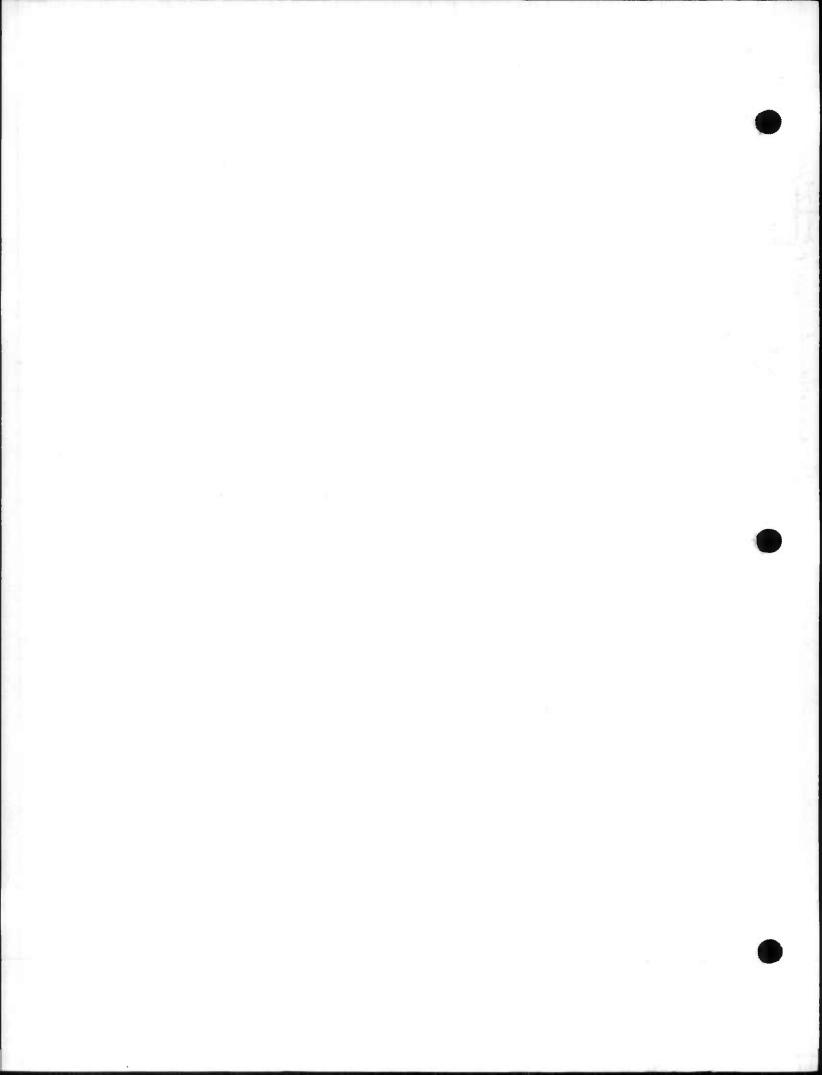
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
- 1	1. DECEDENT'S NAME (First, Middle, Lest) Virginia	Hatcher		Phil:				2. DATE OF DE	EATH DAY	9.		TIME OF DEATH P
		5. SEX 8. AGE (In yrs. 1 M 2 F 78	lest birthday) YRS.	IF UNDER		IF UNDER HOURS	MIN	7. DATE OF BI (Month, Day,	Year)		Country)	CE (State or Foreign
OR	99. FACILITY NAME (If not Institution, give stre Union Hospital		ty	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						Н		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	OR LOCATIO	ON					10-	d. INSIDE CITY
	114127	cil		E	lktor	1					1 [LIMITS?
FUNERAL	9 White Pine C	ircle		101. ZIP CODE 21921						10g. CITIZEN Unit		tates
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Merried 4 Divorced	ARMED NO			cify Cuber	, Mexicen,	C ORIGIN? (Sp., Puerto Ricen,			RACE Black, W Specify: hite		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	ATION 16e. College (1-4 or 5 +)	DECEDENT'S (Give kind of life. Do NOT u	work done	during most		g	16b. KIND	OF BUSI	NESS/INDUST	RY	
MO	17. FATNER'S NAME (First, Middle, Last)					18. MOTH	ER'S NAM	E (First, Middle,	Meiden S	Sumame)		
BE C	Archer B. Hatche	r				Gen	trud	le M. I	Lambe	ert		
5	Gail Muenster							eute Number, CH	Mai	ryland	21	.921
	20e. METNOD OF DISPOSITION 1 Gurlel 2 Cremstion 3 Remov 4 Donetion 6 Other (Specify)	ral from State 20b. PLA	ce and date cremetory or c Ferr	of DISPOS	CO.	ne of		5 PATE	20c. LOC	ation - city	or Town,	State DA
	21. SIGNATURE OF FUNERAL SERVICE LICE		rell	22.	NAME AND			ILITY				, IA.
	Doned	e His	\sim					Funer				21921
	23. PART I. Enter the disesses, or co shock, or heart fellure. Li	mplications that caused the	desth. Do									Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	COACLÃO	ank	ouL	Ice	ilin	10					Onset and Death
	resulting in death) s.	DUE TO (OR AS A CON	ISEOUENCE O	F):	0	-0000	~					78 1118
NO O	disease or condition resulting in death) s. Candrac aut put failure OUE TO (OR AS A CONSEQUENCE OF): Duy To (OR AS A CONSEQUENCE OF): Duy To (OR AS A CONSEQUENCE OF): Duy To (OR AS A CONSEQUENCE OF):											
CAT	If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	+ trasure	- (y)	Jup								
CERTIFICATION	thet initiated events resulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE O	F):								
AL C	PART II. Other significent conditions	contributing to deeth but no	ot resulting	in the ur	nderlying	ceuse g	iven in P		WAS AN A			RE AUTOPSY FINDINGS
EDIC/	chronic abstra	while pulm	mary	di	Liar	2			PERFORM		co	AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
Σ	DID TODA CCO HCF C	ON ITRIBUTE TO 64			P1.1 > 20		110	_			1 [YES 2 NO
PHYSICIAN:	DID TOBACCO USE CO		USE OF	DEA	-		NO EATN (Chec	ck only one)				
YSIC	1 NES 2 TO	HOSBITAL: 1 Inpatient 2 ER/Outpetien	1 3 DOA	OTHER 4 Nun		5 🗆 Re	eldence 6	Other (Spe	clfy)			
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF JURY M	28c. INJU WOR 1 V	IRY AT NK? ES 2		28d. DESCRIB	E NOW IN	JURY OCCUR	ED	
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY — Ai building, atc. (Specify)	t home, ferm,	street, fact	tory, office			28f. LOCATION City or Tow		nd Number or F	Rural Rout	e Number,
COMPLETED		AN: To the best of my knowledge									luse(s) en	id menner ee stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIER	u-				29c. LICE	NSE NUME	02		29d. DATE SI	GNED (MC	onth, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	TEM 27) (Type	n. Print)	9,	1/6	, ,	burt	21/1	20	EI	KTON
	MAY 0 8 1995	12 RECHETBLA'S SIGNATUR	E LL	, ·			- 111			,		10 01701
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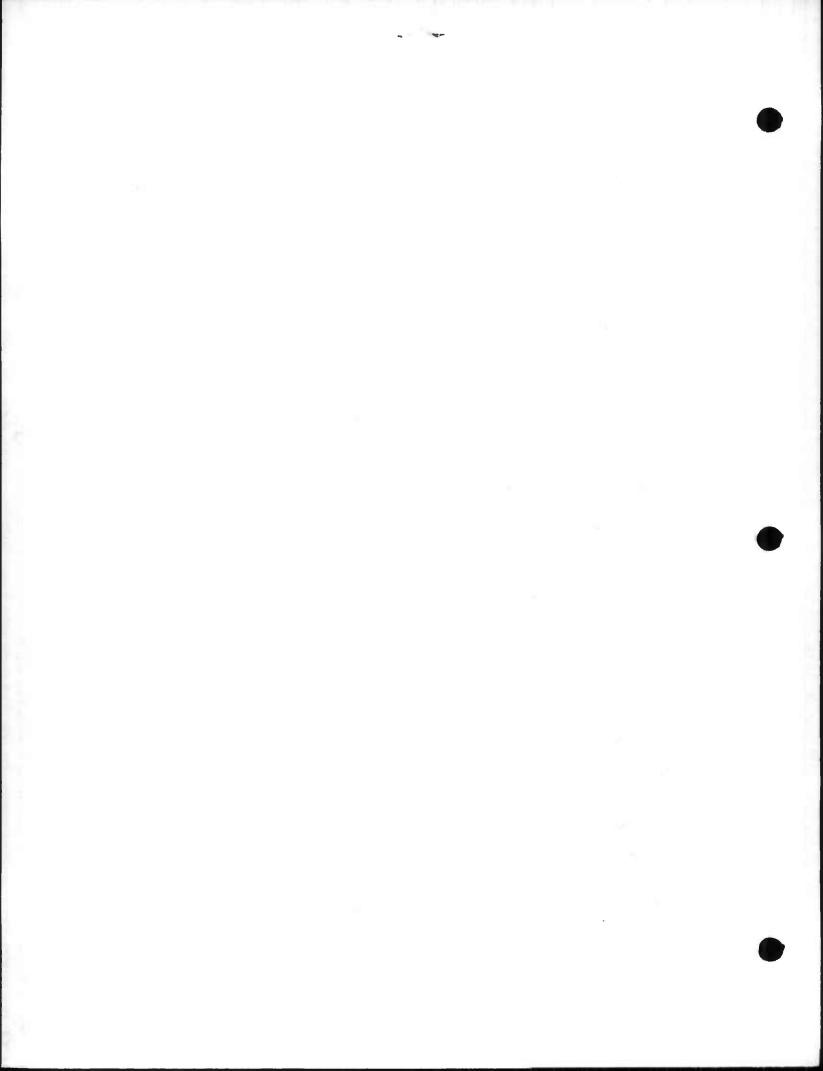


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARY!		TMENT OF H		MENTAL HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH				
	Fay		Proc	tor		1995 YE	1:30 P M				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign ountry)				
	220-62-9143 1 38	YRS.	MONTHS DAYS	HOURS MIN.		1956 พื	ashingtonDC				
_	Sa. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN C	R LOCATION OF DE		9c. COUNTY (
DIRECTOR	Physicians Memorial Hos	pital	La P1	ata		Char1	es				
[គួ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c CIT	Y, TOWN OR LOCAT	ION							
Ē	Maryland Charles	100.01					16d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER		Hughes	ZIP CODE		Tan OFFITTAL	1% YES 2 □ NO DF WHAT COUNTRY?				
FUNERAL	6495 Patuxent Woods Lane			20637		1.50					
=	11. MARITAL STATUS 12. WAS DECEDENT EVER	IN U.S. ARMED	13 WAS DEC		NIC ORIGIN? (Specify Yes	U.S	• A.				
	1 Never Married 2 Married FORCES? 1 YES	★ NO	it yes, spi	cify Cuban, Maxica 2 NO Specifi	n, Puerto Rican, atc.)		llack, White, atc.				
B	3 Widowed 4 Divorced			2 NO Specify		,	Black				
윤	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Ghas kind of	USUAL OCCUPATIO	IN et of working	16b. KIND OF BUS						
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	Me. Do NOT u	se retired.)	or or working							
₽	12	Homen	aker			mestic					
	17. FATHER'S NAME (First, Middle, Lest)				ME (First, Middle, Maiden	Surname)					
BE	Robert A. Proctor		Isido								
2	1.7.	1			Route Number, City or Tow						
- 9	Isidora Proctor	b. PLACE AND DATE			er Rd, Por						
		metery, cremetory or o	thar place)		/8/95 POI						
	21. SIGNATURE OF FUNERAL SURVICE LICENSEE	c.oosep		D ADDRESS OF FA		urrec	Maryranu				
	· 1 (64)						0608				
	23. PART i. Enter the diseases, or complications that cause		Adams	Funer	al Home I	PA Aq					
	shock, or heart feliure. List only one ceuse on	each line.	tot enter the mo	de ot dying, suc	h aa cardiac or respi	ratory arrest,	Approximeta interval Between				
	iMMEDIATE CAUSE (Finel disease or condition providing in death)										
	resulting in death) a. Oue so (on as	A CONSEQUENCE O	P	1	Low	www.					
z	- Vinda	Calus	JANA	Low	7, 0		j				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR MS A CONSEQUENCE OF):									
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	+17	Dry 1	un /	your	U ,					
造	that initiated events resulting in death) LAST	COMBROTIENCE O	00 0	June)						
5	· suce	W C	NO I	Arm							
1	PART II. Other aignificent conditions contributing to death I	but not recuiting	in the underlying	ceuee given in			24b. WERE AUTOPSY FINDINGS				
200					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
¥						AL	OF DEATN?				
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE C	OF DEATH YE	S NO	UNCERTAIN	10						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HQSPITAL:	26. PLACE OF DEA									
PHYSICIAN: MEDIC	1 YES 2 700 Inpetient 2 ER/Out	petient 3 🗆 DOA	OTHER: 4 - Nursing Home	5 🗆 Rasidence	6 Other (Specify)						
H	27. MANNER OF SEATN 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJU	JRY AT RK?	28d. DESCRIBE HOW II	NJURY OCCURE					
BY	2 Accident Investigation			ES 2 NO							
	3 Suicide 6 Could not be 4 Homicide determined	Y — At home, farm, : pcify)	street, factory, office		28t. LOCATION (Street a City or Town, State)	and Number or Ru	rel Route Number,				
<u>E</u>	as aggregation										
COMPLETE	(Check only CERTIFYING PNYSICIAN: To the best of my know										
8	One) 2 MEDICAL EXAMINER: On the basis of axaminetic	on and/or investigation	D, in my opinion, de	eath occured at the	time, data and placa, an	d due to the cau	se(s) and manner as stated.				
B	296. SIGNATURE AND TITLE OF CERTIFIER	~~~		29¢ LICENSE NUN	BER 29	29d. DATE SIGN	NED (Minth Day, Year)				
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	TN (TEM 27) (\$100	Print)	F10.	5. Dm	NOV	6				
	31. DATE FILED (Month, Day, Year) 32. REMISTRAN'S SIGN	NATURE 0	7 , - , 7		3(- 1	2				
	MAY 0 8 1995 Julia di tenes	lear Randall									



Amended Hem#3 5/10/95 C.C. S. CAMpbell

Pages 1, 2, 3 should permit. burial-transit nours after death. Page 6 may be retained by the hospital or attending physician. use as the and completely filled in by the funeral director, page 5 should be detached for o burial, cremation, or removal. notified at once. pe must examiner medicai traumatic event, the 2 attending physician ntal Hygiene prior to other 0 signed by the a Health and Meni shows any this certificate has been with the State Dept. of I item 23 OR ATTENDING PHYSICIAN: The 6 marked, DIRECTOR: After the hours after death v 60 28 hours tem FUNERAL I Ξ HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 7.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIRECTOR

FUNERAL

BY

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COMPL

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

29b. SIGNATURE AND TITLE OF CERTIFIED

SATISH SHAH

31. DATE FILED (Month, Day, Year) MAY 0 8 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia d'Audior harlell

1030 FAIRFIELD ROAD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAP REG NO 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 6 VIRGINIA PITTINGER MAY 1995 -aM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS HOURS See and 1 🗌 M 2 🖫 YRS 214-14-6984 19 FEB. 1918 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3871 MCMULLEN ROAD TANEYTOWN CARROLL 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYT AND CARROLI TANEYTOWN 1 YES 2 NO 10e. STREET AND NUMBER 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3871 MCMULLEN ROAD 21787 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 TES 2X NO Specify 3 Widowed 4 Divorced CAUCASTAN 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementery/Secondary (0-12) College (1-4 or 5+) 7th FOOD PROCESSOR CANNING FACTORY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **JESSE** W **EYLER** MARY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE R. PITTINGER 3871 McMULLEN ROAD TANEYTOWN, MARYLAND 21787 20s. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata TRINITY LUTHERAN CEMETERY 5/10 TANEYTOWN, MARYLAND 21. SIGNATURE OF PLINERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787 23. PART I. Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallura. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** PNW. (ancer disease or condition resulting in death) 1097 DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAIL ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 N Reeldenca 8 □ Other (Specify) 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b, TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural М 1 YES 2 NO 2 Accident Investigation 28s. PLACE OF INJURY — At home, term, street, factory, office 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 🗌 Homicide 29a, CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

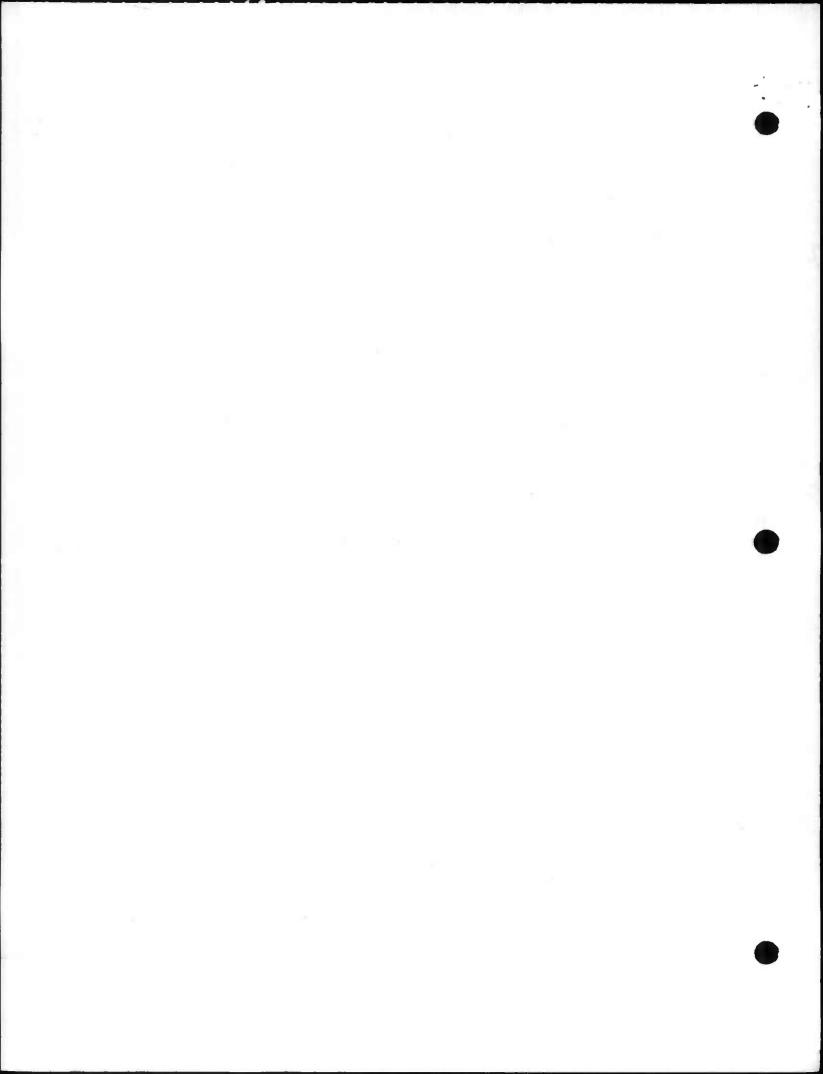
MD0396461

GETTYSBURG, PENNSYLVANIA

1995

29d. DATE SIGNED (Month, Day, Year)

May 8.



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. notified at must be medical examiner injury, or other traumatic event, the shows any TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 is

PHYSICIAN: MEDICAL CERTIFICATION

COMPLETED BY

BE

2

Sequentially list conditions,

If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events

reaulting in death) LAST

1 TES 2 NO

27. MANNER OF DEATH

1 Natural

2 Accident
3 Suicide

4 Homicide

permit. Pages 1, 2, 3 should

									9	5	5527		
	1 - STATE REGISTRAR	STATE OF MARY			TMENT O			MENTAL HYGIEN REG. NO.	E				
	PARRISH ALI	BERT RAYMO	OND	PARI	RISH			2. DATE OF DEATH DA	"6/	YEAR 95	3. TIME OF DEATH 7 - 10 P.M		
	4. SOCIAL SECURITY NUMBER 219-12-0262	1 - MACE	E (In yrs. les 78	t birthday) YRS.	IF UNDER 1 Y	EAR AYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 9, 19	17	e. BIRTHE PENNS	YLVANIA		
TOR	98. FACILITY NAME (If not institution, give street end number) CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER RESIDENCE OF DECEMENT							ATH					
. DIRECTOR		ROLL		NEW	y. Winds	OCR"	ON				10d. INSIDE CITY LINUS? 1 YES 2 NO		
UNERAL	2623 MARSTON RD.	6	10g. CIT	U.S	A.								
BYF	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed Mar Phiomed	IN U.S. ARI S 2 N DATES		If ye	s, spec	NOENT OF HISPAN city Cuben, Mexicar 2 NO Specify	IC ORIGIN? (Specify Yee n, Puerto Ricen, atc.)	or No—	14. RACE Black, Specific WHI	— American Indian, White, etc.			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Gi	CEDENT'S Ve kind of v Do NOT us	USUAL OCCU work done during the retired.)	PATION og mos	of working	SCHOOL BUS/MILK TRUCK					
BE CON	17. FATHER'S NAME (First, Middle, Last) RAYMOND A. PARRIS				ME (First, Middle, Meiden Surneme) 7. L. REPP								
2	190. INFORMANT'S NAME (Type/Print) EDNA S. PARRISH				ADDRESS (SE			Oute Number, City or Town	n, State, Zi	p Code) MD	21776		
	20e. METHOD OF DISPOSITION BUR 1 Burlet 2 Cremetion 3 Rem 4 Donation 6 Other (Specify)		ERS	CEMETE	RY		5/9 NR	. NE		IDSOR, MD			
	21. SIGNATURE DE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS NEW WINDSOR, MD												
	23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final	List only one cause on	aach iine.				6	aa cardlec or reapli	ratory ar	reat,	Approximata Interval Batween Onset and Death		
	disease or condition reaulting in death)	MASSIVI	EH	HEN	10 RRI	14	sic (K	DCVA			Lours		

PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. LIPIDEMIA

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 VIO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

HOSPITAL:
1 Inpatient 2 - ER/Outpatient 3 - DOA OTHER: me 5 - Reeldence 6 - Other (Specify)

28e. DATE OF INJURY 26b. TIME OF INJURY 26c. INJURY AT WORK? 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify)

1 YES 2 NO

29e. CERTIFIER viadge, death occurred at the time, date end place, end due to the cause(e) end manner ee atated.

29b. SIONATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2. 17 WASHINGTON

29c. LICENSE NUMBER 015

HGTS

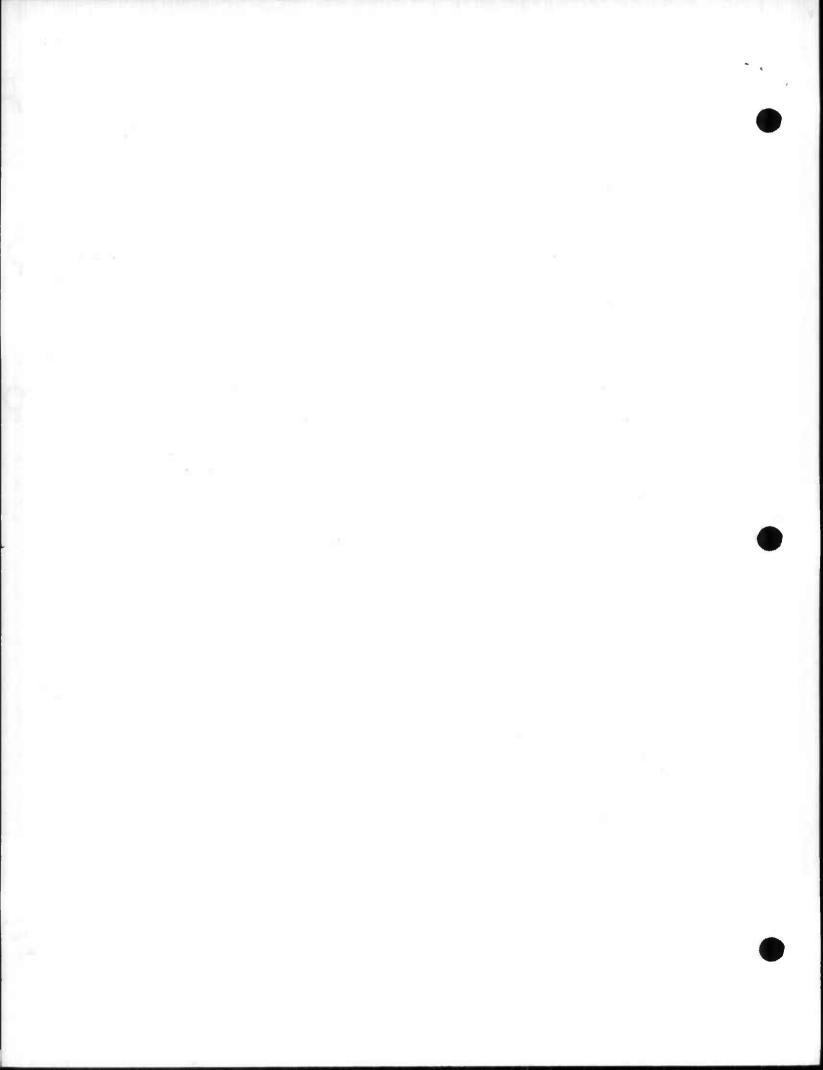
95

WESTMINSTER

31. DATE FILED (Month, Day, Year)
MAY U & 32. REGISTRAR'S SIGNATURE

6 Could not be

a welson Kerdall



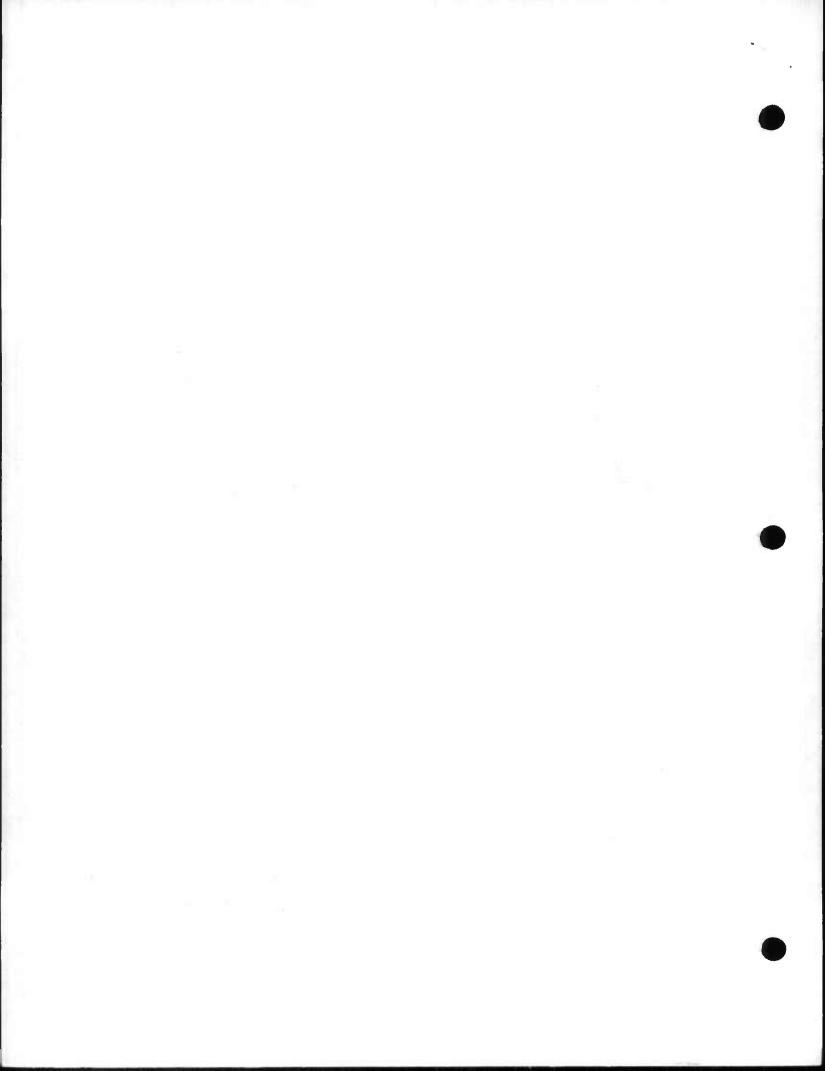
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	s filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
1 1 1 1	る元	be filed	IMPO

as	o O										9	5	5528
	1 - FOR STATE REGISTRAR	STATE OF I		/ DEPAR					MENTAI	HYGIEN REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF OEATH			3. TIME OF OEATH
	LOIS	E.		PR	ICE				MAY	05 "	199	5 YEAR	11:19 P m
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	lest birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		8. BIRTHI	PLACE (State or Foreign
	213-64-6490	1 □ M 2 □XF	37	YRS.	MONTHS	DAYS	HOURS	MIN.	Sep	1 2 1	957	Pen	nsylvania
	9e. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY	TOWN (OR LOCATI	ON OF OR		1-4		NTY OF DE	
۳ ا	ST. JOSEPHS HO	OSPITAL				Bal	ltim	ore			BA	LTIM	ORE
DIRECTOR	RESIDENCE OF DECEDENT												
1 2				10c. CIT	Y, TOWN C							- 1	10d. INSIDE CITY LIMITS?
	Maryland Bal	timore		<u> </u>		_	nkto						1 YES 2 NO
A A		+ 1 0 0 0				101	ZIP COD		4		10g. CIT		HAT COUNTRY?
FUNERAL	916 Maple Hurs							111				US	
3	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEOEN FORCES? 1	T EVER IN U.S. A	NO	13.	WAS DEC	ENDENT C	of HISPAN	NIC ORIGIN	7 (Specify Yes	or No-	14. RACE Black	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE V	WAR OR DATES	•	1	_ YES	2X NO	Specify	y:			Specify	
Ω	15. DECEDENT'S EDU	CATION	16a. C	DECEDENT'S	USUAL O	CUPATIO)NI		146	KIND OF BUS	DINEGO/INI	MIOTOV	WILLCE
1 1 1	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of the Do NOT u	work done (se retired.)	during mo	st of worldr	ng	100	KIND OF BOX	3114533/1141	DOSINI	
1	12	College (I-4 or 5	" P	osta	1 0	lerk	<			U.S.	Po	stal	Service
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				_		18. MOTI	HER'S NA	ME (First. A	fiddle, Malden	Sumamel		
	George H. Dann	er					Рa	uli	ne R	obert	S		
BE	19e. INFORMANT'S NAME (Type/Print)		1	19b. MAILING	AODRESS	(Street e	nd Number	or Rural F	Route Numb	er, City or Tow	n. State. Zie	n Code)	
5	Robert A. Pric	e 3rd		916	Map:	le H	durs	t L	ane,	Monk	ton	, MD	21111
	20e. METHOD OF DISPOSITION		20b. PLACI	EANDDATE	OF DISPOS	ITION (Na	me of	:	DATI	20c. LO	CATION —	City or Toy	n. State
	1 Donation 5 Other (Specify)	oval from State	cemetery, c	remetoryor 1	ther place)	emat	tion	S		Han			
	21. SIGNATURE OF POWERAL SERVICE LIC	ENSEY /	71		22.	NAME AN	D ADDRE	SS OF FA				-	1 Home
	* Steves	W. 8	lu	e						Hamps	stea	d, M	D 21074
	23. PART I. Enter the diseeses, or a hock, or heart failure.	complications the List only one cau	t caused the dise on each life	leath. Do i	not enter	tha mo	de of dy	ing, suci	h as cerd	lac or respi	ratory ar	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel	41	, ,										Onset and Death
	disease or condition resulting in death)	Arter	iosele	olic	Caro	lion	raser	Ma	· di	sease			
		OUE TO	(OR AS A CONS	EQUENCE O	F):								
NO	Sequentielly list conditions,	b					_						
F	if any, leading to immediate cause. Enter UNDERLYING	DOE TO	(OR AS A CONS	EUUENCE O	F):								
ERTIFICATION	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONS	FOUENCE O	FI-								
E	resulting in death) LAST		(,.								j
빙		d											
A	PART II. Other significant condition	s contributing to	deeth but not	resulting	in the un	derlying	cause (given in	Part I.	24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
[음 [_	1 1 YES 2		- 1	COMPLETION OF CAUSE DF DEATH?
MEDICAL													1 X YES 2 NO
	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	1 🗆 8	10 L	UNC	ERTAIN	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL/	ACE OF DEA									
YS!	1 N YES 2 □ NO	1 Inpatient 2	ER/Outpatient	з (Хроа	OTHER		6 5 🗆 Re	sidence	8 🗆 Other	(Specify)			
품	27. MANNER OF DEATH	26e. DATE OF (Month, D	INJURY ey, Year)	28b. TIM	E OF URY	28c. INJ	URY AT		28d. DE\$	CRIBE HOW II	NJURY OC	CURED	
à	1 Natural 5 Pending 2 Accident Investigation				М		ES 2	NO					
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE O building,	FINJURY — At I etc. (Specify)	nome, farm,	street, facto	ory, office				ATION (Street a	and Number	or Rural Ro	ute Number,
릴	29a. CERTIFIER 1 CERTIFYING PHYSI												
COMPL	2 X MEDICAL EXAMINE	R: On the baels of e	xamination and/o	r Investigatio	n, in my o	pinion, d	eath occur	ed at the	lime, data	end place, en	d due lo It	ne ceuse(s)	end manner as stated.
w	29b. SIGNATURE AND TITLE OF CERTIFIER	1 , ,						NSE NUM					Month, Day, Year)
1 00 1		1. 11	110			- 1	0	$^{\circ}$ M	100		► M	AV A	6 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

DONALD G. MAY 0 8 1995 111 Penn Street, Baltimore, Maryland 21201



1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

			1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE C	F DEATH		T	3. TIME OF DEATH
				Ma	rthe	Steeve	s l	Peders	en			MONTH	ril 26	w 19	95	2239 м
			4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. I		IF UNDER 1		IF UNDER	24 HRS.	7. DATE O	F BIRTH		8. BIRTHP	LACE (State or Foreign
			023-42-487	0	1 M 2 F	40	YRS.	MONTHS	MY8	HOURS	MIN.		Day, Year)		Country)	
	3 should		9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY, T	OWN O	R LOCATIO	ON OF DE		3133	9c. COU	NTY OF DE	ATH
	ຕ	B B	Peninsula	Region	nal Medic	al Cent	er		Sa	alisb	nırv			L u	licom	ico
	£.	یا	RESIDENCE OF DEC	10b. COUNT		dz bene					, ary		WICOMICO			
	Page	DIRECTOR		TOB. COOK!	¥		10c. Ci1	Y, TOWN OR								10d. INSIDE CITY LIMITS?
	Ĭ.		New Hampshire					Merri	7							YES 2 NO
	burial-transit permit. Pages 1, 2,	FUNERAL							10f.	ZIP CODE						IAT COUNTRY?
Ce	trans	N N	Lindenway		12. WAS DECEDEN	T 51/50 (1) 110 .					3054				SA	
320	burial	1 1	1 Never Married 2 🗵	Married	FORCES? 1	YES 2K		H)	es, spe	city Cuba	n, Maxican	, Puerto Ri	(Specify Yes can, atc.)	or No—	Block,	- American Indian, White, etc.
0-	2	B	3 Widowed 4 Divo	proed	IF YES, GIVE W	WAR OR DATES		1 10	YES	2 K NO	Specify:				Specify Whi	
AND 21215-0020	detached for use as the	ETED	15. DEC	EDENT'S EDU	CATION			USUAL OCC				16b. I	CIND OF BUS	INESS/IND		
27	for c	9	Elementary/Secondary (6		College (1-4 or 5		e. Do NOT u	work done dur se retired.)	ng mos	st of worten	rg					
9	ched	COMPL	12		4		House	wife								
A a		8	17. FATHER'S NAME (First, M										ddle, Malden	Surname)		
Z Z	20 to	BE	Spurgin		teeves						Made:				Bar	be
MARYLAND	5 should notified	2	19a. INFORMANT'S NAME (1		ADDRESS (S								00054
	8 0	-	Andrew Ste								errıı	mack,	New	Hamps	shire	03054
BALTIMORE,	director, page er must be		1X Burial 2 Crematic	n 3 🗆 Rem	oval from Stata	20b. PLACE cemetery, cr	AND DATE	of dispositi ther place) t Cemi	ON (Ner	me of		DATE			City or Town	
M	direc er m	- 1	4 Donation 8 Other		ewick /	Las	t Kes		_			5/3	M	errı	mack,	NH
5	death. Pag tuneral dir I. examiner		Holloway Funeral Home													
BA after de	47 TH T		XKY	11.4	follow	5	_	50)] (Snow	Hill	L Rd.	, Sal	isbur	y, M	D 21801
	25 3		23 PARD I. Enter the di shock, or h	eart failure.	complications that List only one cap	t caused the d	eath. Do	not enter th	e mod	de of dyle	ng, such	aa cardi	c or respli	ratory arr	est,	Approximate
ST ST ST			IMMEDIATE CAUSE (FIR				•									Interval Between Onset and Death
			disease or condition resulting in death) a. Multiple Trauma Minutes													
6876C	E - 2		DUE TO (OR AS A CONSEQUENCE OF):													
	pri pri	ON		uentially list conditions, b. Auto accident oue to (or as a consequence of):												
O B	or g	AT	If any, leading to imme- cause. Enter UNDERLY		002 10	(ON NO A CONSE	OUENCE O	r):								
.	ing physician pother in	윤	CAUSE (Disease or Injuthat Initiated events	iry	cDUE TO	(OR AS A CONSE	OUENCE O	F):								
S, P.O. B(attending phy intal Hygiene ry, or other	CERTIFICATION	resulting in death) LAS	7	d											
S, l	the atter Mental njury, o		DART II Other elevition	nt non-distant											-	
RECORDS,	ed by the att th and Menta any Injury.	MEDICAL	PART II. Other algnifice	ent condition	is contributing to	death but not	resulting	in the unde	rlying	cause g	given in F	Part I. 2	4a. WAS AN		1	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
O fi	signed Health a	ă										-	YES 2	NO		OMPLETION DF CAUSE OF DEATH?
Or e	been sign of Hea shows	Σ	DID TODA CCO II	CE COLIT						. 1. 10 10					1	☐ YES 2 ☐ NO
<u></u> ≥	as b	SICIAN: N	DID TOBACCO U		KIBUIE IO CA			S L NO	_	UNC	ERTAIN					
VISION OF VITAL ATTENDING PHYSICIAN: The I	State (22	EXAMINER?	J MEDICALE	HOSPITAL:			OTHER:								
F V	certificate the State I, or iten	PHYS	27. MANNER OF DEATH		28a. DATE OF		28b. TIM	4 Nursin	Home c. INJU				Specify)	IIIBY OCC	TIBED	
PHYSIC	fer this eath with marked			Pending	(Month, Da	ey, Year)		URY	WOF	RK7	,		nicle			
ONIG	After death	ВУ	a Da sate	Investigation Could not be	28a, PLACE O	F INJURY - At h	ome term	street tector	offica		-	2mt. LOCAT	ION (Street a			
DIVISION OR ATTENDING	DIRECTOR: After hours after death Item 28 is ma	ETED		determined	High	way Rou	te 17	75				City or	nac Co			
0 8	DIR	7	29a, CERTIFIER 1 CERT	FYING PHYSI	CIAN: To the beat of	my knowledge d	eath occur	ad at the time	data	and alone						51111d
HOSPITAL	70 =	COMPL														and manner as stated.
H08	TO THE FUNERA De filed within 7 IMPORTANT: 1	11	29b. SIGNATURE AND TITLE			-										
뿔	For Field	BE	110	١١ ح	01.	a. o	DME				NSE NUMI	BEH				Aonth, Day, Year)
2	28₹	2	30 MAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITE	DME M 27) (Type	Print)	_	(D) 35	99				4/27,	75
			John T. Bul			.08 Pine			d,	Sali	sbur	y, M	218	301		
			31. DATE FILED (Month, Day,	Year)	32. PEGISTRA	R'S SIGNATURE	4 -		_							
	6		MAY 0	2 1995	32. MEGISTRA	aucher la	Melh									
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- 1

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

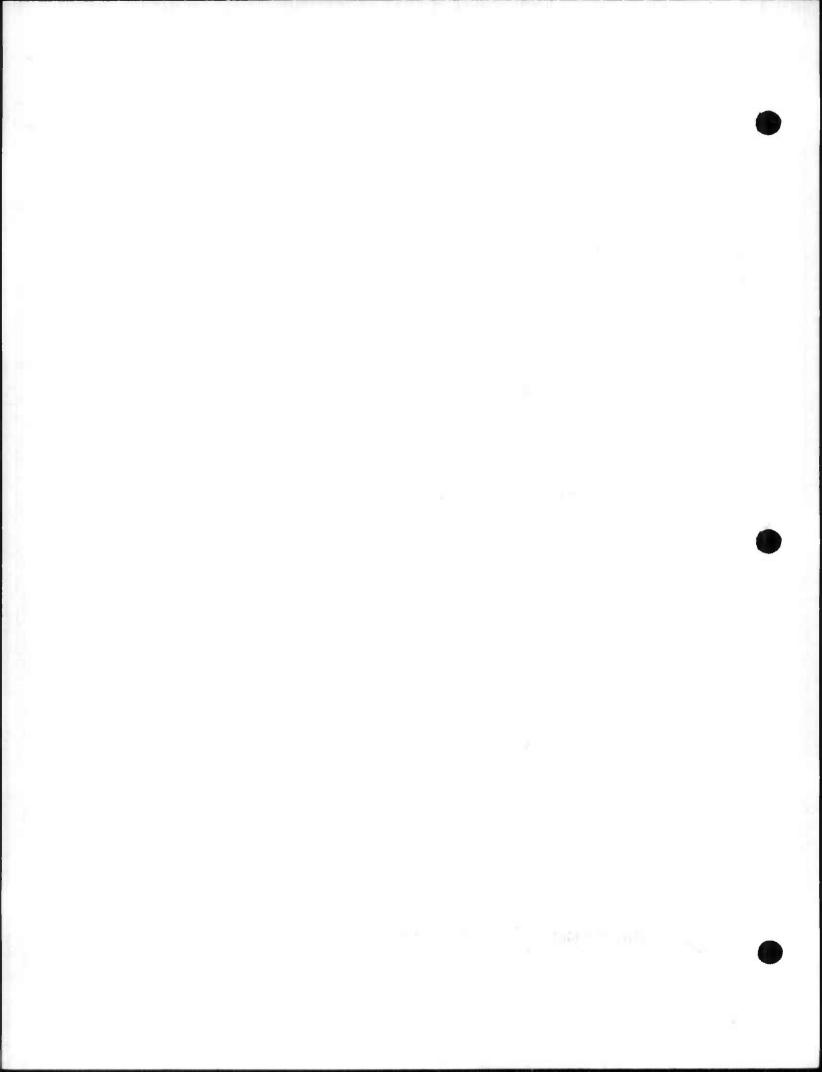
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH															
	ROBERT	T	ERRANCE		PA	RKO	5 A	4		A P	3	19	YEAR	08:40Au		
	4. SOCIAL SECURITY NUM	BER	5. SEX	6, AGE (In yrs. I		IF UNDER 1		IF UNDER		7. DATE OF (Month, C	BIRTH		8. BIRTH Count	IPLACE (State or Foreign		
	216-48-547	-	1 M 2 F	48	YRS.	MONTHS	DAYE	NOURS	MIN.	May 13		5		ryland		
~	9a. FACILITY NAME (If not in	nstitution, give a	treet and number)			9b. CITY,	bb. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
DIRECTOR	PENINSULA		AL MEDIC	AL CENT	ER	5	AL]	ISBUR	Y			W	ICOM	ICO		
E C	10a. STATE	10b. COUNTY	1		10c. CITY	TOWN OF	LOCAT	TION						10d, INSIDE CITY		
百	Maryland	Wi	comico			Sal	isb	ury						LIMITS?		
AL	10e. STREET AND NUMBER						101	f. ZIP CODI	E			10g. CIT	IZEN OF V	WHAT COUNTRY?		
FUNERAL	118 Benja	min Av	е.					2 18	301				USA	1		
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13. W	AS DEC	ENDENT C	F HISPAN	IIC ORIGIN? (Specify Yea	or No-	14. RACI	E — American Indian, k, White, stc.		
BY	1 Never Married 2 X	,,,,			2 NO			in, etc.)		Spec	My:					
	15. DEC	CEDENT'S EDU	CATION	160 0	ECEDENT'S L	101141 000	MIDATI	ON					Wh:	ite		
	(Specify onli Elementary/Secondary (I	ly highest grede	completed) College (1-4 or 5		Give kind of wi	ork done du	ring mo	ost of working	ng	100, KI	ND OF BUS	INCSS/INI	JUSTRY			
집	12	5-12)	Conede (1-4 0) 2		Counte	r Sa	les			He	ating	g & A	Air (Conditioning		
COMPLETED	17. FATHER'S NAME (First, M	fiddle, Last)						18. MOTI	HER'S NAI	ME (First, Mide	fle, Meiden	Surname)				
BE	John Edg	ar Pa	rker					Le	eona			Ma	addox	ς .		
ဋ	19a. INFORMANT'S NAME (1	9b. MAILING	AODRESS	Street a	and Number	or Rural F	loute Number,	City or Town	State, Zip	Code)			
-	Joanne Par								e.,	Salist						
	20a. METHOD OF DISPOSIT	on 3 🗆 Rem	ovel from State		emetory or oth					5/1			City or To			
	4 Donation 5 Other		ENGLE	Wice	omico			I Pa			_ sa	LISD	ıry,	MD		
	1/4h	NV	Inna-	/		1	lol	loway	Fur	neral						
-	Jana 1	11.19	race you	ray			501	Snov	v Hil	ll Rd.	, Sa	lisbu	ıry,	MD 21801		
ı	23. PART I. Enter the d shock, or h	eart fallure.	List only one cau	it caused/the d issoon each lin	eath. Do no e.	ot enter t	he mo	da of dyl	ng, auch	n aa cardlad	or reapli	atory an	reat,	Approximata Interval Between		
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Me fact afec Malignar Melanora DUE TO (OR AS A CONSEQUENCE OF):											Onset and Death					
1	resulting in death)	→	a. ne re	OD AS A CONS	/Us/	.5 7	a.	1	ne /o	nora						
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2	Sequentially list condit if any, leading to imme		DUE TO	(OR AS A CONSE	OUENCE OF)	:										
<u>₹</u>	cause. Enter UNDERLY CAUSE (Disease or Inju	ING	D													
	that initiated events		DUE TO	(OR AS A CONSE	OUENCE OF)	:										
Ы		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.														
			3													
	PART II. Other algnifica	int condition	s contributing to	death but not	resulting in	the und	erlying	g cause g	given in i	Part I. 24	a. WAS AN		24b.	WERE AUTOPSY FINDINGS		
	PART II. Other algoritica	nt condition	s contributing to	death but not	resulting in	the und	erlying	g cause g	given in i		a. WAS AN A PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUSE		
	PART II. Other algnifica	ent condition	s contributing to	death but not	resulting in	the und	erlying	g cause g	given in i		PERFOR	WED?	24b.	AMILABLE PRIOR TO		
MEDICAL	DID TOBACCO U	ISE CONTI								1	PERFOR	WED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TEXAMINER?	ISE CONTI	RIBUTE TO CA	USE OF DE	ATH YES	S N	0 [1	PERFOR	WED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TI EXAMINER? 1 YES 2 NO	ISE CONTI	RIBUTE TO CA	SUSE OF DE/ 28. PLA ER/Outpatient	ATH YES	OTHER:	O L] UNC	ERTAIN	1	PERFOR	WED?	24b.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident	SE CONTI O MEDICAL	HOSPITAL: 1 Computer 2 2 28e. DATE OF (Month, D	26. PLA 28. PLA 28. PLA 28. PLA 29. PL	ATH YES	OF M	O [UNC 0 5 Re URY AT ORK? YES 2	ERTAIN	8 Other (S	PERFOR YES 2 Decify) BE HOW IN	JURY OC	CUREO	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
BY PHYSICIAN: MEDICAL	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8	SE CONTRO MEDICAL	HOSPITAL: 1 Sanpatient 2 [28a. DATE OF (Month, D) 28a. PLACE O	USE OF DEA	ATH YES	OF M	O [UNC 0 5 Re URY AT ORK? YES 2	ERTAIN	8 Other (S 28d, DESCR	PERFOR YES 2 Decify) BE HOW IN	JURY OC	CUREO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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31. DATE FILED (Month, Day, Year)

fours after death. Page 6 may be retained by the hospital or attending physician.	tely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh	nation, or removal.	t, the medical examiner must be notified at once.
es that the death certificate be executed with	gned by the attending physician and complet	atth and Mental Hygiene prior to burial, cren	ws any injury, or other traumatic event, the me
ITENDING PHYSICIAN: The law requires that t	TOR: After this certificate has been sig	after death with the State Dept. of He	d, or Item 23 sho
TO THE HOSPITAL OR ATTENDING PH	THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death will	MPORTANT: If Item 28 is marke

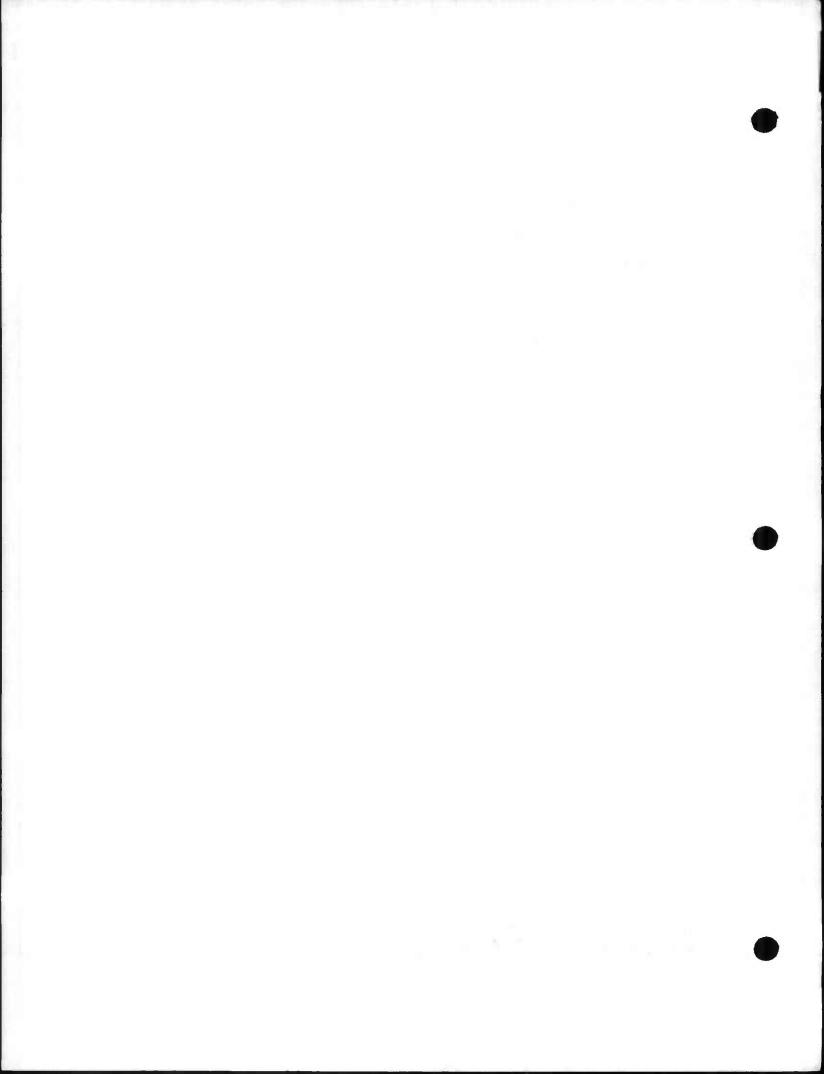
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Reid YEAR Gerald 95 samue (04 2:300M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE STUTE OF FORDIGE A 1 M 2 | F 578-11-8869 59 09 09 WEST INDIES Se. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Fox Chase Rehab, and Mursing Center Silver DIRECTOR Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION N/A N/A WASHINGTON, D.C. XX YES 2 NO FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 802 KENNEDY STREET, N.W. 20011 S. A. U. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES SYNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1X Never Married 2 Married YES 2 TO Specify: Specify: BLACK BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12th HOUSE KEEPING PRIVATE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) ROBERT REID RACHEL PRICE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 JENNIFER BONGORE (NIECE) 802 KENNEDY STREET, N.W.; WDC 20011 20a_METHOD Of DisPOSITION

(X) Quriel Commettee 3 X X amoval from State
4 Donation 5 Dother (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE JEFFREY S FAMILY PLOT5/7/95 MARY'S, JAMAICA ST. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOHNON AND JENKINS FUNERAL HOME 716 KENNEDY STREET, N.W. wdc 20011 23. PART : Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. Ust poly one ceuse on each line. Approximate Interval Between Onset and Death **IMMEDIATE CAUSE (Finei** disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) CERTIFICATION DUE TO (OR AS A CONSEQUENCE OF) rema Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) H 17Know-CAUSE (Disease or injury thet initieted events resulting in death) LAST PART ii. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a WAS AN AUTOPSY 1 YES 2 1 NO 1 YES 2 J-NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHEB 1 - YES 2 110 Inpetient 2 - ER/Outpetient 3 - DOA 4 A Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building. etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide determined 1 EXERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CHICK IEF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Davidson-Rarball

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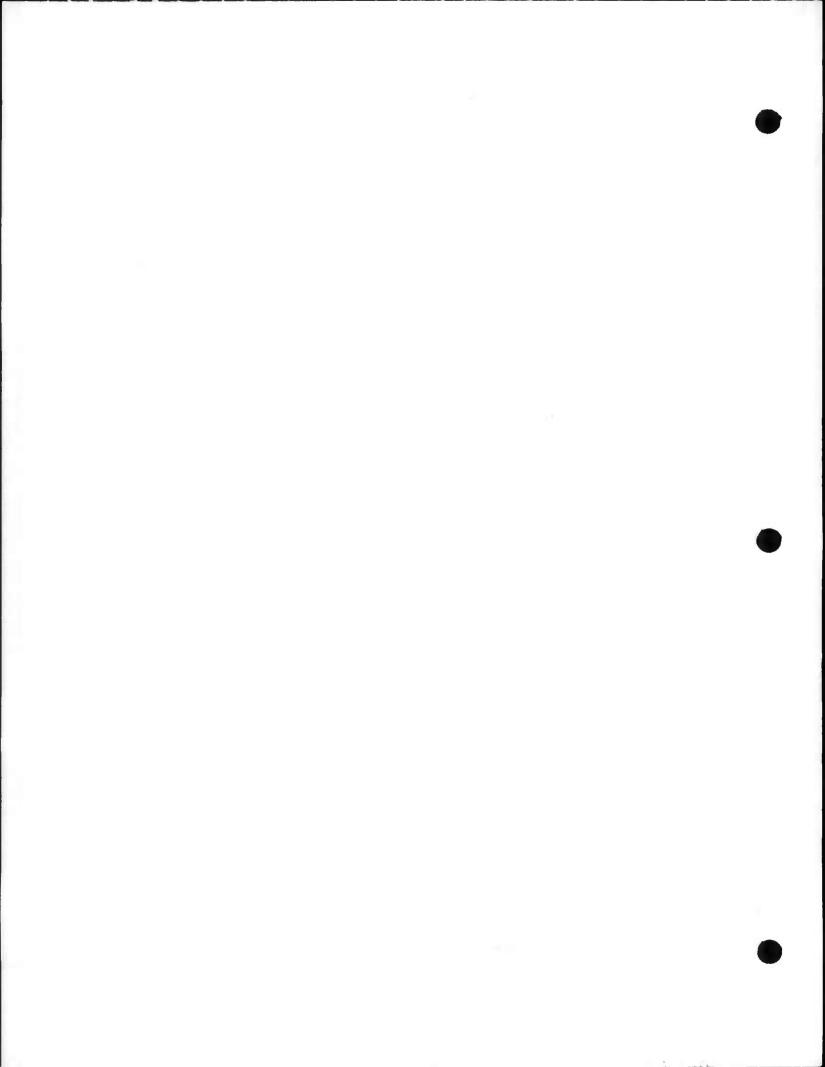


BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician	d in by the funeral director, page 5 should be detached for use as the burial-tra
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within FF hours after death. Page 6 may be retained by the hospital or attending physician	THE TUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans
(/	5
4),	

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

									- 0.	DEAI	-		REG. NO.			
		1. DECEDENT'S NAME (First, Richard										2. DATE OF	F DEATH DA	W	YEAR	3. TIME OF DEATH
				utledge									1 29,	199		7:55 P.M. M
		4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE ('in yrs. lest	birthday)	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF	BIRTH Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
20		177 18 703		12 M 2 □ F	7	4	YRS.	MONTHS	DATE	HOUNE				920		" sylvania
3 should	~	9a. FACILITY NAME (If not in	stitution, give e	treet and number)				9b. CITY	r, TOWN	OR LOCATIO	ON OF DE	ATH			NTY OF D	
r,	DIRECTOR	12506 Kem	bridge	Drive				В	owie	2				Prin	ce G	eorge's
es 1	EC	10a. STATE	10b. COUNTY				10c. CITY	, TOWN	OR LOCAT	TION				77		10d, INSIDE CITY
Te.	H	Maryland	Princ	e George	's		Bow	ri e							- 1	LIMITS?
Sermi	AL	10e. STREET AND NUMBER							101	. ZIP CODE				10g. CITI	ZEN OF V	WHAT COUNTRY?
burial-transit permit. Pages 1,	FUNERAL	12506 Kemb	ridge	Drive						2071	5			Uni	ted	States
ag-tra	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER I	U.S. ARI	MED	13.	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN?	(Specify Yes		14. RACE	- American Indian
	ВУ Б	1 Never Married 2 3 Wildowed 4 Divo		FORCES? 1			0			ecity Cuber		, Puerto Ric	an, etc.)		Speci	t, White, etc.
as the																White
	COMPLETED	(Specify only	EDENT'S EDUC highest grade	CATION completed)		16a. DEC	CEDENT'S	ork done	during mo	ON ost of working	g	16b. K	IND OF BUS	INESS/IND	DUSTRY	
D	PE	Elementary/Secondary (0	-12)	College (1-4 or 5 -	·)		ieral							0	-	
detache once.	₩.	17. FATHER'S NAME (First, M.	iddle Lest)			Ger	ierai	Mai	lage.	_	EDIO MAA	AE (First, Mid	iildi		ibbTZ	7
a	EC	James Rutle										uther		Sumame)		
5 should notified	0	19e. INFORMANT'S NAME (7)	0			19b	MAILING	ADDRESS	S (Street e			oute Number,		State Zin	Codel	
	5	Mary Anne R	utledg	e												id. 21037
		20e. METHOD OF DISPOSITI			20b	PLACEA	NO DATE O	EDIEBOE	TION IN	ama al		0.475	20- 100	2471011	04	
nuneral director, p xaminer must		4 Donation 6 Other (Specify) Cremation 3 N Removal from State Commetery, premajory or other place) Northside Catholic Cemetery 5/5/95 Pittsburgh, Pa.														
e runeral di il. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBert E. Evans Funeral Home, P.A.														
. Tune		RMXOT	18	CIPIA	10	P	7	1	6000	\ Ann	cva	ns ru is Rd	neral	Hom	e, P	.A.
or removal.		23. PART I. Enter the di	seases, or c	omplications that	t caused	the day	eth. Do n	ot enter	the mo	de of duli	apor.	IS Ku	. DOW	Te M	a. Z	Approximate
or re		anock, or na	aart tallure. I	List only one cau	se on e	ach line.		87.55					o or respir	atory an	wat,	Interval Between
the the		IMMEDIATE CAUSE (Finel disease or condition Find Stage Congestory heart failur 34														
crem.		disease or condition resulting in death) End Stage Congestive heart failur DUE TO (OR SE A CONSEQUENCE OF): Chronic Obstructive Palmonny disease Sequentially list conditions, litary, leading to immediate Due TO (OR AS A CONSEQUENCE OF):														
suprect by the attending physician and compressly me Health and Mental Hygiene prior to burial, cremation, we any injury, or other traumatic event, the	z	Chronic obstruction palmonnes ducas														
to b	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
prio	2	CAUSE (Disease or inju		Ren			-									2 years
othe	E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST														
tal Hy	#	d														
th and Menta any injury,		PART II. Other significa	nt condition	contributing to	deeth b	ut not re	sulting in	n the un	derlying	g ceuse g	lven in F	Part I. 24	fa. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
h and	MEDICAL			Celitus									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									_			- '	☐ YES 2	₩V		OF DEATH?
20 0		DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE O	F DEAT	H YE	S 🔲 I	NO [UNC	ERTAIN	- P				. II TEG Z DENO
State Dept.	M	25. WAS CASE REFERRED TO EXAMINER?					OF DEAT	H (Check	only one)							
the State Dept	PHYSICIAN	1 VES 2 NO		HOSPITAL:	ER/Outp	etient 3	□ DOA	OTHER 4 - Nun		o 5 Ales	idence 6	Other (S	Specify)			
	E	27. MANNER OF DEATH		28a. DATE OF (Month, Di			28b. TIME		28c. INJ	URY AT		28d. DESCR	NIBE HOW IN	JURY OCC	CURED	
death with t	BY		Pending nvestigation					M	1 🗌 Y		NO					
ler de	8		Could not be	28e. PLACE Of building,	F INJURY etc. (Speci	— At hom	ne, farm, st	reet, lect	ory, office			281. LOCATI City or	ON (Street as Town, State)	nd Number	or Rural R	oute Number,
hours after of item 28 is			retermined			_										
F 54 ==	길			CIAN: To the best of												
N B	COMPL	one) 2 MEDI	CAL EXAMINE	R: On the besis of ex	amination	end/or In	vestigation	, In my o	plnion, d	eath occure	d at the ti	lme, date an	d place, end	due to the	e cause(e)	end menner ee stated.
DETA	w II	29b. SIGNATURE AND TITLE	OF CERTIFIER							29c. LICE				29d. DATE	SIGNED	(Month, Day, Year)
THE WITH THE	0 8	Poit Fal-								D 4:	344	6			5/1	195
-)	-	30. NAME AND ADDRESS OF														
5/		ROINTAN F	ARAHI	- FAR M	D.	4000	M.	tche	lle V	ille R	Dad	B21	6 Bo	wie	MD	20716.
		31. DATE FILED (Month, Day,)	rbar)	32. REGISTRA	R'S SIGNA	ATURE										
UN	ال	MAY 02 1995	- Oak	is Stander	Food	all.										
		101121 0 0 10 00 0	1 10													The same of the sa



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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Injury.

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Item 23

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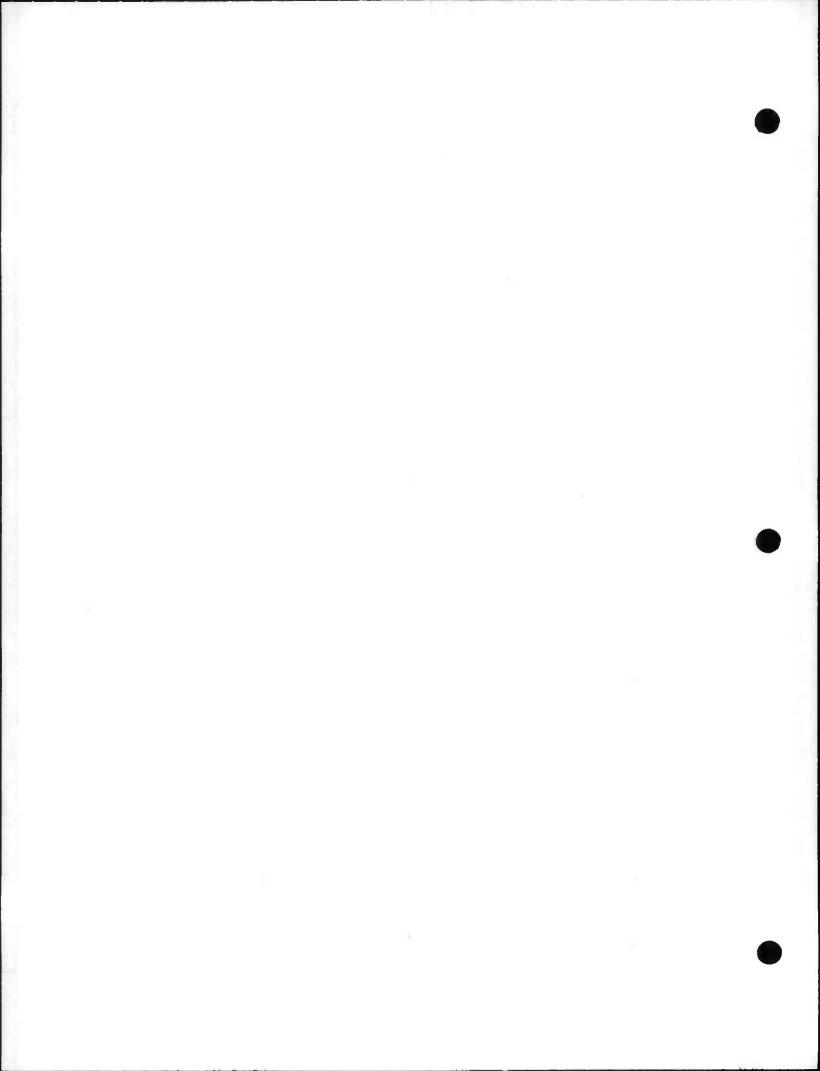
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permit. Pages 1, 2, 3 should

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. PLIMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HIGHTAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this Think will 72 hours after death w

													95)	15533	}			
	1 - FOR STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR RTIF	ITMEN ICAT	T OF H	IEALTH DEA	AND I		YGIEN EG. NO.	E						
	1. DECEDENT'S NAME (First,	, Middle, Last)									2. DATE OF E	EATH	ow.	YEAR	3. TIME OF DEAT	н			
	ANGE			R]	ENALD	Ι					APRIL			1995	3:00	Α			
	4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE	(In yrs. lesi	t birthday)		R 1 YEAR	IF UNDER		7. DATE DF B	IRTH		6. BIRT	HPLACE (State or For	reign			
	578-48-2185		1 🔀 M 2 🗆 F	91		YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 2		904	Ita	,,				
	9a. FACILITY NAME (If not in	stitution, give s	treet end number)				9b. CIT	Y, TOWN	OR LOCATI	ON OF DE		<u>, , , , , , , , , , , , , , , , , , , </u>		Bc. COUNTY OF DEATH					
DIRECTOR	Prince Geor	ge's H	lospital	Cent	er		Che	ever	Ly				Pri	Prince George's					
EC	10a. STATE	10b. COUNTY	,			10c, CIT	Y. TOWN	DR LOCAT	TION						10d, INSIDE CITY	_			
DIR	Maryland	¹s				sburg			4		1 YES 2	ND							
AL	10e. STREET AND NUMBER								ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?				
띰	5415 Tilden Road 20710								10			Ur	nite	d States					
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced				2 K N	MED		If yes, sp	ENDENT Cooling Cube	n, Mexice	NIC ORIGIN? (Sp n, Puerto Rican. V:	ecify Yes , etc.)		United States Who Is a Company of the Country? United States In No- Identify the Country of					
COMPLETED	15. DEC (Specify only	EDENT'S EDUC	CATION completed)		16e. DE0	CEDENT'S	USUAL C	CCUPATIO	ON st of working		16b. KINI	OF BUS	INESS/IN	DUSTRY					
91	Elementary/Secondary (0		College (1-4 or 5	+)	life.	Do NOT us	se retired.)	doing inc	at or worter	·v									
MP	10				Bar	ber					Se1	f-En	ploy	red					
8	17. FATHER'S NAME (First, Mi								18. MOT	HER'S NA	ME (First, Middle	, Maiden 3	Surname)						
BE (Salvatore R	inaldi							Sant	a Pr	estifi	lipp	0						
10	19e, INFORMANT'S NAME (7)	ype/Print)			19b	. MAILING	ADDRES	S (Street e	nd Number	or Rural I	Route Number, Ci	ty or Town	, State, Zij	Code)		т			
F	Frances Bel	1			7	Par	lian	ent	Cour	t, E	Baltimo	re,	Mary	lano	1 21212				
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Removal from State 4 Donalton 5 Other (Specify)				PLACE A	NDDATE	OF DISPO	SITION /Ne			DATE 20c. LOCATION — City or Town, State 5/2/95 Brentwood, Maryland								
	21. SIGNATURE OF FUNDINAL	SERVICE LIC	ENGLE (1 1.	1		22.	NAME AN	D ADDRE	SS OF FA	Gury Funeral								

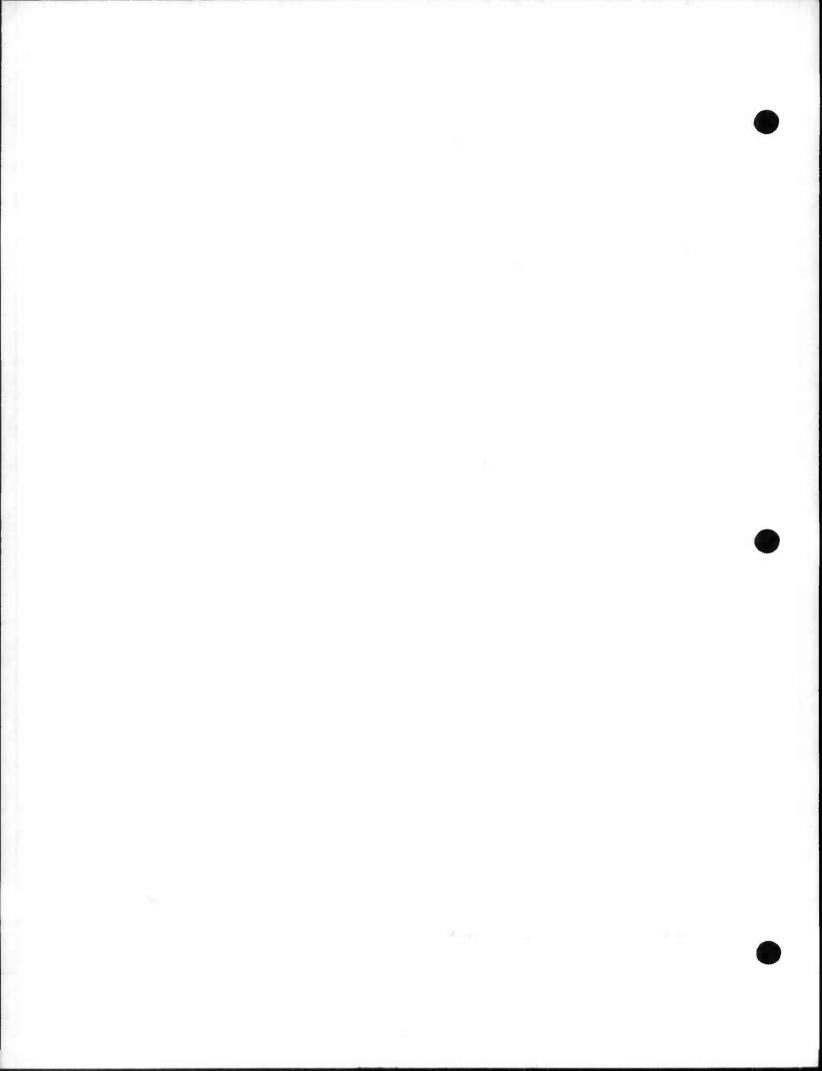
BE COMPLETED 2 3401 Bladensburg Rd., Brentwood, MD 20722 23. PART I. Enter the diseases, Dr complicatione that caused tha death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, ahock, or heert fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) acute congestive heart facture 3 days DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF) CERTIFICATION decades Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING rheumatic heart 8 decades CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY PERFORMED? 1 | YES 2 - NO 1 YES 2 ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL: 1 YES 2 ND 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 26e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Netural BY 1 YES 2 NO 2 Accident investigation 3 Suicide 28e. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street end Number or Bural Boute Number, City or Town, Stete) COMPLETED Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. 29b, SIGNALD 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 022700 4/29/95 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Schister MO 7500 Greenway Ctr. Dr. Weeg belt Hed 20770 31. DATE FILED (Month, Day, Year)
MAY 02 1995 32. REGISTRAR'S SIGNATURE
JULIA DAWLLON-RANDALL DHMH-16 Rev 1/89



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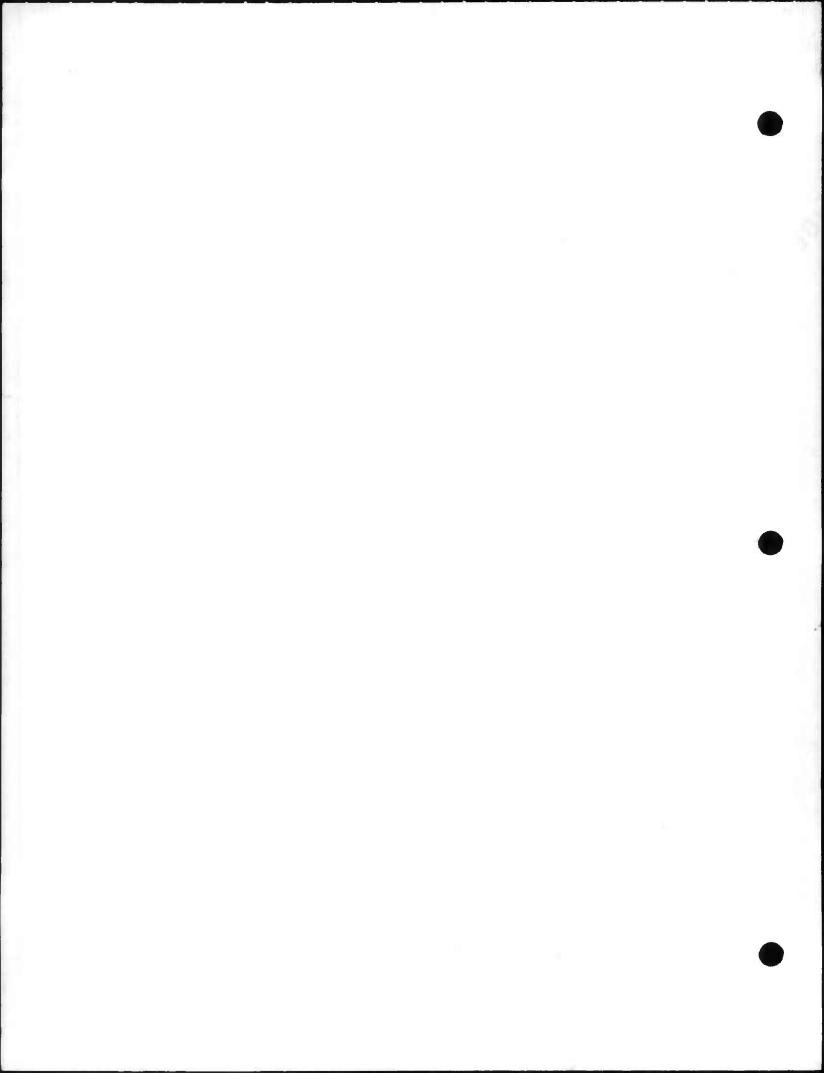
SICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician. Certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.	ical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	
TO THE MISHALL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Dept., of Health and Mental Hygiene prior to burial, cremation, or remonal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF I	DEATH			3. TIME OF OEAT	н
	THOMAS EUGENE	RENTZ				April	30 ·		YEAR	6:00	рм
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E	HRTN		. BIRTH	PLACE (State or Fo	
	255-20-3910	1 ⊠ M 2 □ F 72	YRS.	ONTHS DAYS	HOURS MIN.	Nov. 9	, 19	22	Geo	rgia	
_	9e. FACILITY NAME (If not institution, give str	reet and number)	1	b. CITY, TOWN (R LOCATION OF D	EATH		9c. COUNT	Y OF D	EATH	
DIRECTOR	5108 69th Place			Hyattsv	ille			Princ	ce (George's	
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION					10d. INSIDE CITY	
8	Maryland Prince	George's	I .	Hyattsv						LIMITS?	
	10e. STREET AND NUMBER				. ZIP CODE		T	10g. CITIZE	N OF W	HAT COUNTRY?	NO
FUNERAL	5108 69th Place				20784			U.S.	Α.		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No.— 14. RACE -							— American India	n,		
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		NO If yes, specify Cuben, Maxican, Puerlo Rican, atc.) 1 YES 2 NO Specify:					Specif		
	15. DECEDENT'S EDUC						White				
	(Specify only highest grade of	completed)	(Give kind of wor life. Do NOT use	rk done during mo	st of working	16b. KIN	16b. KIND OF BUSINESS/INDUSTRY				
3	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Linguist	t		Nat:	ional	Secu	ırit	y Agenc	v
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				16. MOTHER'S NA					,	
BEO	Arthur Bunn Ren	ntz, Sr.			Leon	Hade	n				
01	19a. INFORMANT'S NAME (Type/Print)		The second secon		nd Number or Rural				,		
۲	Marie S. Rentz		5108 (69th P1	ace, Hya	ttsvil	le, M	laryla	and	20784	
	20s. METNOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Cremation 3 ☐ Remo		PLACE AND DATE OF			DATE		ATION - CH			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		etary, crematory or othe tropolita				Alex	xandr	ia,	Virgini	.a
	21. SIGNATURE OF POWERAL SERVICE CO	INSEE		Franc	id address of fa is Gasch	's Sons	s Fun	eral	Hon	ne. P.A.	
	W.D.E	1-eiser		4739	Baltimor	e Ave.	Hvat	tsvil	lle.		781
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused list only one cause on er	the death. Do not	enter the mo	de of dying, suc	h as cardiac	or reapin	atory arres	nt,	Approxima	
	IMMEDIATE CALISE (Final	1004000 000		-11		a.		1		Onset and	
	disease or condition resulting in death)	NON SA		ELL L	-010	CAN	rek			14	R
_		DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):		-					-	
CA	cause. Enter UNDERLYING	223								İ	
Ē	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
E	reaulting in death) LAST										
AL C	PART II. Other significant conditions	contributing to death be	ut not resulting in	tha undariying	cause given in	Part i. 24s	WAS AN A	UTOPSY	24b	WERE AUTOPSY FIN	IDINGS
₫	8						PERFORM	ED?	1	AVAILABLE PRIOR T	0
밀						_	YES 2 [MO		OF DEATH?	,
=	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAI	NIA				I C 1ES 2 C N	۱ ا
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATN								
l Si		HOSPITAL: 1 Inpetient 2 ER/Output		THER:	5 Ansidence	6 Other (Spi	ecify)				
H	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJ	JRY AT RK?	26d. DESCRIE	E NOW IN.	JURY OCCU	RED		
à	2 Accident Investigation M 1 YES 2 NO										
	3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, tarm, street, factory, office City or Town, State) 28t. LOCATION (Street and Number or Flural Route Number, City or Town, State)										
	29s. CERTIFIER (Check only (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
COMPLET	(Check only	E: On the basis of examination								55	
		- On the basis of azamination	and/or investigation,	in my opinion, a							rted.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER	(No)	/		29c. LICENSE NUI	WBER LOI	7	29d. DATE S	BIGNED	(Mbnth, Dey, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE DE DE	ITN (ITEM 27) (Type De	rine)	1 20	70		- 5	111	42	
	Dr. Joseph Hagger	//	dical Cen		122 #200	Pooles	, 1 T T ~	MD	200	50	
	31. DATE FILED (Month, Day, Year)			reer DI.	LVE 1/300	, KUCKY	ттте	, MID	208	JU	\rightarrow
MAY UI 1995 julia visualia visualia											



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	TAL OR ATTENDING PHYSICIAN: The
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		FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYG				
		1. DECEDENT'S NAME (First, Middle, List) BRANDON TRAYVON ROBINSON 2. Date of Death Month 26, 1995 PARTIE 26, 1995							year 3. TIME OF DEATH 4:00 A M		
pin		4. SOCIAL SECURITY NUMBER	1 XM 2 - F	in yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Month, Day, Ye April 26,	er)	BIRTHPLACE (State or Foreign Country) ARYLAND		
, 2, 3 should	ECTOR	9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL PRINCE GEORGES 9b. CITY, TOWN OR LOCATION OF DEATH PRINCE GEORGES 9c. COUNTY OF DEATH PRINCE GEORGES									
ít. Pages 1,	DIREC	10a, STATE 10b. COUNT	CE GEORGES		Y, TOWN OR LOCA KON HILL		10d. INSIDE CITY LIMITS? 1 [X YES 2 \sum NO				
n. ansit permit.	VERAL	[11378 SOUTH VIEW DRIVE, #203 20745						U.S.A	N OF WHAT COUNTRY?		
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 (XNO	If yes, sp		NIC ORIGIN? (Speci an, Puerto Rican, et fy:	C.)	4. RACE — American Indian, Black, White, etc. Specify: Black		
D 2121 spital or atte	APLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	CaTION e completed) College (1-4 or 5+)		VISUAL OCCUPATION OF POLITICAL OCCUPATION OCCUPATI		16b. KIND 0	F BUSINESS/INDUS			
YLA by the be det	BE COMP	17. FATHER'S NAME (First, Middle, Last) ERIC LEWIS ROB	INSON			16. MOTHER'S NA YOLONE	ME (First, Middle, M DA THOMAS	aiden Surname)			
E, MA be retain ge 5 sho e notifi	TO E	190. INFORMANT'S NAME (Type/Print) Patricia Pope		196. MAILING 6632	APDRESS (Street of Stanton	Road, Hy	Route Number City of ACCSVIII	e, MD Zip C	20784		
Page 6 m Il director, ner must		20s_METHOD OF DISPOSITION 1 \(\) Burlal 2 \(\) Cremation 3 \(\) Ren 4 \(\) Donetion 5 \(\) Other (Specify) 21. SIGNATURE OF TURERAL SERVICE LI	noval from State ceme	PLACE AND DATE (PLACE), crematory or o PLIMONY M	emorial 22. NAME A	Park	5/3/95 :	Landover,	The state of the s		
BALTIN hours after death. Pag ed in by the funeral di or removal. medical examiner		23. PART I Enter the diseases, or	complications that caused	the death Do	9013 A	nnapoli	m Funeral s Road	, Lanha			
ion in		ahock, pr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	RESPIRATO	RY FAI	LURE	nde or dyring, auc	m sa cerdiec or	reapiratory arrea	It, Approximate Interval Between Onset and Death		
OX 58750 be executed within sician and completely rior to burial, crema traumatic event,	NO	Sequentially list conditions,	DUE TO (OR AS A IMMATURIT	Y (22	Weeks	Gestat	ion)				
th certificate ending physical Hygiene por other	ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	cDUE TO (OR AS A								
COKIDS, P. res that the death igned by the atten ealth and Merral I R any Injury, or	MEDICAL CEI	PART II. Other algnificent condition	ne contributing to death bu	it not resulting	n the underlyin	g ceuse given in	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
AL RECORD e law requires that the has been signed by th Dept. of Health and I 23 shows any Ini	IN: ME	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	F DEATH YE	s 🗆 no 🗆	UNCERTAI	N 🗆		1 TES 2 NO		
SICIAN: The certificate har the State D	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpa	te. PLACE OF DEAT	OTHER:	ne 5 🗆 Residence	6 Other (Specify)			
Re the PHY C	ву рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	URY AT DRK? YES 2 NO		OW INJURY OCCU			
ON ATTENDING ORRECTOR: After hours after death item 28 is ma	ETED.	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special	fy)			City or Town,	State)	Rural Route Number,		
로 글은 =	COMPLE	2 MEDICAL EXAMINI	ICIAN: To the best of my knowle								
TO THE HOSPI TO THE FUNEF De filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	wh, M.	D.		D27	G 28	29d. DAYE S	t -26-95		
		30. NAME AND ADDRESS OF PERSON WI	3. FRATTA	ROLA	Print) UD	300 1	Logu	tal 8,87	ntal Center		
		MAY 05 1995	32. REGISTRAR'S SIGNA	TURE		Che	usyin	nd -	20785		

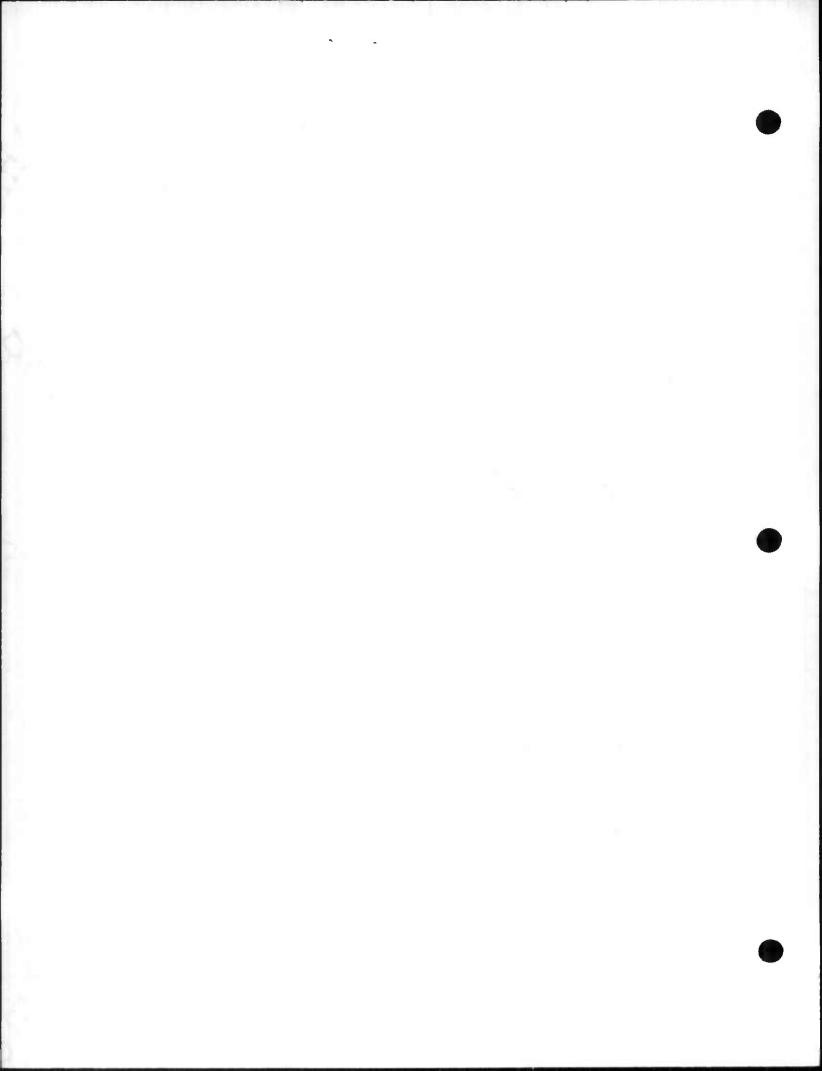


BALTIMORE, MARYLAND 21215-0020

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4. 9/1 100 M. 111 1 3	17 19 20 12 4	19	20 2 4		2 is d	S If CI CI THE	P	25	27.	29	29	
TO BE COMPLETED BY FUNERAL DIRECTOR	E COMPLE	TO B				O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	: MEDICAL C	SICIAN	ED BY PHY	MPLET	BE CC	0
	at once.	notified	ner must be	exami	ent, the medica	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	shows any injury	Item 23	28 is marked, or	f. If Item 2	PORTAN	Ξ
e has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should is Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	be detached for	5 should	il director, page	the funera	pletely filled in by cremation, or remo	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	been signed by the a	State Dep) THE FUNERAL DIRECTOR: After this certificate if filed within 72 hours after death with the State	ERAL DIRECT	THE FUNE filed withir	23
or attending physician.	by the hospital	retained	Page 6 may be	ter death.	within 24 hours at	0 THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	requires that the de	N: The lav	TENDING PHYSICIA	OTAL DR AT	THE HOS	2

	REGISTRAR		CERTIFIC	AIL OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	Allen K	FGI	CT	Fρ	2. DATE OF DEATH	n , 1000	3. TIME OF DEATH 12:00 A		
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1. BI	RTHPLACE (State or Foreign		
	243-26-3870 A	OJ YRS.	AONTHS DAYS HOURS MIN. AUG 5, 1986, 1986 BB. CITY, TOWN OR LOCATION OF DEATH			25 No.	rth Carolina			
OB	Southern Maryland	,		Clint		EATH	Prince	George's		
집	RESIDENCE OF DECEDENT 10a. STATE									
DIRECTOR	Maryland Princ		Capitol Heights				LIMITS?			
FUNERAL	9403 Hickory Park	Street		10	20743		United States			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	IN U.S. ARMED 2 N NO DATES	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Veg or No. 14. BACE - America							
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S US	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY						
COMPLETED	Elementary/Secondary (0-12)	Cotlege (1-4 or 5+)	life. Do NOT use n	etired.)	ost or working	Diamond	Cab Co	moany		
Ö	17. FATHER'S NAME (First, Middle, Last)	L (d) 11	river	18. MOTHER'S NA	ME (First, Middle, Maiden		angeary			
BE C	Onless A. Regist 19a. INFORMANT'S NAME (Type/Print)				Williford					
2	Evelyn R. Regist				Aoute Number, City or Town		hts, Md 20743			
	20a, METHOD OF DISPOSITION 1 Squared 2 Cremation 3 Rame 4 Donation 6 Other (Specify)	oval from State Co		DISPOSITION /A	ame of May A	1995 200 100	CATION — City o			
	21. BIGNATURE OF FUNERAL SERVICE LIC	ENGEL	HICOTH FICH	22. NAME A	ND ADDRESS OF FA	outy Lee Fun	eral Ho	me.Inc 6633		
	· ASSA	de		old A	Lexander	Ferry Road	, Clint	on, Maryland		
7	23. PART I. Enter the diseases, or candick, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. M Q DUE TO (OR AS	esch ilne.	^		genic		Approximats Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF):			•	٠	,		
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying gauge given in Part I. Charm c Das m. Cure live and provided the underlying gauge given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	OF DEATH YES	□ NO [UNCERTAIL	N D		1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH							
ı⊀S	1 YES 2 NA	1 Impatient 2 - ER/Out	patient 3 DOA 4	The state of the s						
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y W	28c. INJURY AT WORK? M 1 YES 2 NO					
- 4	3 Suicide 8 Could not be detarmined 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, afc. (Specify) 26b. PLACE OF INJURY — At home, farm, street, factory, offica City or Town, State) 26c. City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and placa, and dua to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my optnion, dasth occurred at the time, data and placa, and dua to the cause(s) and manner as stated.									
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	d.M.D			29c. LICENSE NUM	ABER	29d. DATE SIGN	ED (Month, Day, Year)		
۱	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Pri	7107	Pivion	st ta	ubl. L	Lille Md		
	31. DATE FILES (MAY) 1 0 1995	32. DEGISTRAS'S SIE	HOT RANGELL			1		2070		



1 -	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART CERTIFIC	MENT OF H	EAUTH AND	MENTA	L HYGIEN	E		
	DECEDENT'S NAME (First, Middle, Last)	ROUCI	ROUCH 2. DATE OF C					E OF OEATH		
2	SOCIAL SECURITY NUMBER 204-05-6853 D. FACILITY NAME (If not institution, give s	1 □ M 2 😾 F	6. AGE (In yrs. last birthday) 12 F 7 4 YRS. 15 UNDER 1 YEAR IF UNDER 24 HRS. 16 UNDER 24 HRS. 17 DATE OF BIRTH (Morth, Day, Year) 18 ONTHIS DAYS HOURS MIN.				OF BIRTH	920	PLACE (State or Foreign y) Yland	
	Saint Joseph Medic				on, Mary			9c. COUN	Itimo	
M M	a. STATE 10b. COUNTY aryland Car s. STREET AND NUMBER		town on Locat	ter					10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL 11.	485 Pleasanto	on Rd.		101	21157				.S.	A.
3 [MARITAL STATUS Never Married 2 Married Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 XNO	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexic 2 1 NO Speci	an, Puerto	Y? (Specify Yes Rican, etc.)	or No-	Black	- American Indian, t, White, etc. WWhite
COMPLETED 17.	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	life. Do NOT use	rk done during mo retired.)	DN st of working	16b	. KIND OF BUS			
E 17	FATHER'S NAME (First, Middle, Last)								er	
	Joseph J. F		Anton:			Sumame)				
194	. INFORMANT'S NAME (Type/Print)	aviovsky	19b. MAILING A	DDRESS (Street a	nd Number or Rural			State Zin	Corte	
2 1	Frederick Henr	y Rouch								d. 21157
15	a. METHOD OF DISPOSITION Burlel 2 Cremation 3 Rem Donation 6 Other (Specify)	oval from State	Ob. PLACE AND DATE OF emetery, crematory or other	DISPOSITION (Na	me of	DAT	E 20c. LOC	CATION — C	alty or To	wn, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
	Nany L. FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER									ER, MD.
1M die	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition RIGHT BRONCHOGENIC CARCINOMA									
1	Due TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE Sequentially list conditions,									YEARS
CA Ch	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PA	PERFORMED? 1 YES A NO OF								WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ğ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
ś	1 YES 2 NO	OSPITAL:	tpatient 3 DOA 4	THER:	5 🗆 Residence	8 Other	r (Specify)			
	MANNER OF DEATH Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME (Y WOI	RK?	28d. DES	CRIBE HOW IN	JURY OCCI	URED	
	2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide M 1 VES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route City or Town, State)								oute Number,	
290	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. Description of the basic of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. Description of the basic of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated.									and manner as stated.
296	Pb. SIGNATURE AND TYPLE OF CERTIFIED 29c. LICENSE NUMBER D 25886 D 26886 D 26886						(Month, Day, Year)			
	NAME AND ADDRESS OF PERSON WHO LIA CEBALLOS, M.	D., 7620 YOR	EATH (ITEM 27) (Type, Pr		NAJYFAN	D 212	04			
	DATE FILEO (MONTH, Day, Year)	32. REGISTRAR'S SIG	NATURE		·					

FAV 5736

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RIGHT BRONCHOLE VILLARONOIVA

CORONARY ARTER! DISEASE

BIGHT PROVONORVEUVONA

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LUA CEBALLOS VIDI IELE TORA ROAD TOWELL VARILAND FOM

DIVISION OF VITAL RECORDS, P.O. BOX 68760

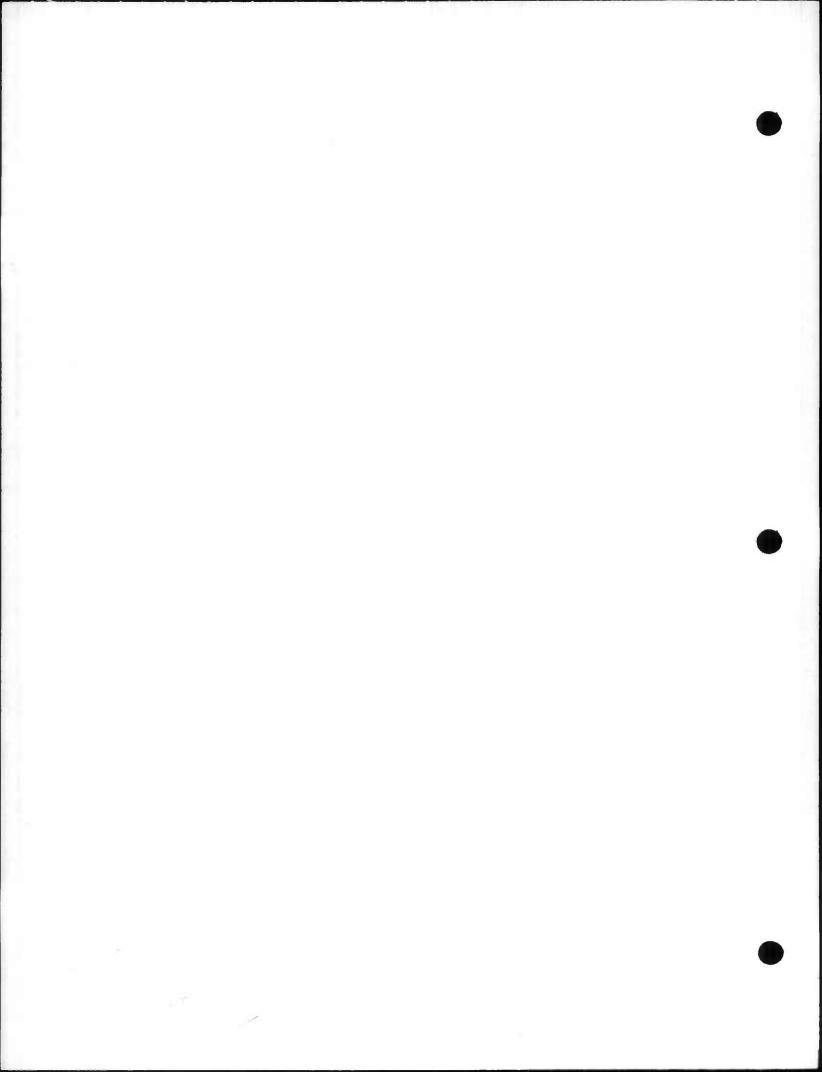
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	TIEGIOTTIAN			ENIIF	CALE	UL	DEALL	RI	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH								3. TIME OF DEATH			
	Benjamin Charl			es Reynolds				April 28 1995 5:45				5:45 PM
	4. SOCIAL SECURITY NUMBER	8. AGE (In yrs. I	est birthday)	IF UNDER 1	-	IF UNDER 24 HRS.	7. DATE OF 8 (Month, Day	IRTH		a. BIRTH	PLACE (State or Foreign	
- 7	114-07-2758 1∑™2□F 86			YAS.	MONTHS	DAYS	HOURS MIN.	August		1908	Countr	"England
	9a. FACILITY NAME (If not institution, give at				9b. CITY, T	OWN O	A LOCATION OF DE				NTY OF D	
OH	Holy Cross Hospital				Si	lvei	r Spring		- 1	Mor	ntgon	nerv
5	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY			40.000								
DIRECTOR					r, TOWN OR							10d. INSIDE CITY LIMITS?
	10e, STREET AND NUMBER	ntgomery		Ta	koma	-						1 YES 2 X NO
FUNERAL	7051 Carroll Aver	nio Ant i	1100			10f.	ZIP CODE		10g. CITIZEN OF WHA			HAT COUNTRY?
N	11. MARITAL STATUS	12. WAS DECEDENT					20912		\perp			.A.
	1 Never Married 2 Married	FORCES? 1	YES 2 💢	NO	If y	res, spe	ENDENT OF HISPAN cify Cuban, Maxica	n, Puerto Rican	ecify Yes (, etc.)	or No—		- American Indian, , White, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WA	R OR DATES		1 [YES	2 X NO Specify	<i>r</i> :		- 1	Spech	White
G	15. DECEDENT'S EDUC		16a. D	ECEDENT'S	USUAL OCC	UPATIO	N	165 KIND	OF BUSI	NESS/INC	HISTRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w le. Do NOT us	vork done dur	ing mos	it of working	100.1010	01 0001	142 30/1142	7031KI	
릴		1	Vi	olini	st			Mı	sic			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA			urname)		
BEO	Benjamin Reynolds						Fanny	Parke	r			20
	19a. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	AODRESS (S	Street ar	nd Number or Rural I			State, Zip	Code)	
2	Sheila A. Nichols	on										inia 22020
	20e_METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Remo	uml danus State	20h PLACE	ANDDATEC	E DIEBORITI	ON (No.	me of	0.75	204 100	MOUTA	Otto: T	- 04-4
	4 Donation 5 Other (Specify)	other places s Cemetery 5/3/95 Brandywine, Marylan							Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LIC		Francis J. Collins Funeral Home, Inc.									
	James 5	Jooly			[500	Un	iversity	Blvd.	W. S.	il.S	pr.	Inc. MD 20901
	23. PART I. Enter the diseases, or callock, or heart failure. I	omplications that	caused the d	leath. Do n	ot antar th	a mod	fa of dying, such	h as cardiac d	or respire	itory arr	est,	Approximate
	IMMEDIATE CAUSE (Final	list Only Ona Cause										interval Between Onset and Death
	disease or condition resulting in death)		ŀ	MI	144	10	MA					
	manus an ameri	DUE TO (O	R AS A CONSE	OUENCE OF):							
Z	Sequentially list conditions, b.											
CERTIFICATION	If any, leading to immediate	DUE TO (O	AS A CONSE	OUENCE OF):							
2	CAUSE (Disease or injury											
Ë	that initiated events resulting in death) LAST	DUE 10 (0	R AS A CONSE	OUENCE OF):							
5												
	PART II. Other significant conditions	contributing to d	eath but not	resulting i	n the unda	rlying	cause given in	Part I. 24a.	WAS AN A	UTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL	RENAL INSU	MABRUF	NEW	MOTH	HOTZAN	2			PERFORM			AMAILABLE PRIOR TO COMPLETION OF CAUSE
	RENAL INSU	IRICION	ey N	TALN	UTRIT	702	, proces	THAT PAT	V	_ 110		OF DEATH?
≥	DID TOBACCO USE CONTR	IBUTE TO CAU	SE OF DE	ATH YE	S D NO	οП	UNCERTAIN	ומיו	/			TES ZUENO
₹	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT				. 45				
C 1	EXAMINER?	HOSPITAL:	R/Outpatient	3 DOA	OTHER:	g Home	5 - Residence	8 Other /Son	cifv)			
Sic	1 TYES 2 NO	1 YES 2 NO 1-Competient 2 ER/Outpatient 3 DO. 27. MANNER OF DEATH 28a. DATE OF INJURY 28b.						28d. DESCRIBI		URY OCC	CURED	
HYSIC	1 TYES 2 NO					WOR						
Y PHYSIC	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF IN (Month, Day,		INJ		1 🗌 YI						
8	1 VES 2 NO 27. MANNER OF DEATH	(Month, Day,	Year)	INJ	М			28f. LOCATION	(Street an	d Number	or Rural R	oute Number,
8	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation	(Month, Day,	Year)	INJ	М			28f. LOCATION City or Tow	(Street en	d Number	or Rural R	oute Number,
8	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined	(Month, Day, 28a, PLACE OF (building, ate	Year) INJURY — At h	oma, ferm, a	M treet, factory	, office	ES 2 NO	City or Tow	n, State)			oute Number,
8	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	(Month, Day, 28a, PLACE OF building, at	Year) INJURY — At h c. (Specify) y knowledge, d	ome, ferm, at	M treet, factory	, office	ES 2 NO	City or Tow	n, State) end mann	or an state	ed.	
COMPLETED BY	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be detarmined 29a. CETIFIER (Check only One) 2 MEDICAL EXAMINER	(Month, Day, 28a. PLACE OF building, at the best of many in the best of axar	Year) INJURY — At h.c. (Specify) y knowledge, dimination and/or	ome, ferm, at	M treet, factory	, office	end place, end due	City or Tow to the cause(e) time, data and p	end mann- eleca, and	or as state	ed. e cause(s)	and manner as stated.
BE COMPLETED BY	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be detarmined 29a. CETIFIER (Check only One) 2 MEDICAL EXAMINER	(Month, Day, 28a, PLACE OF building, at	Year) INJURY — At h.c. (Specify) y knowledge, dimination and/or	ome, ferm, at	M treet, factory	, office	end place, end due ath occured at the	City or Tow to the cause(e) time, data and p	end mann	or as state	ed. e cause(s)	and manner as stated.
BE COMPLETED BY	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be detarmined 29a. CETIFIER (Check only One) 2 MEDICAL EXAMINER	(Month, Day, 29a. PLACE OF I building, at EIAN: To the best of my 1: On the best of axar	Year) INJURY — At h.c. (Specify) y knowledge, dimination and/or	ome, ferm, at	M treet, factory	, office	end place, end due ath occured at the	City or Tow to the cause(e) time, data and p	end mann	or as state	ed. e cause(s)	and manner as stated.
TO BE COMPLETED BY PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 2 Accident Investigation 3 Sulcide 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND AOORESS OF PERSON WHO	29a. PLACE OF building, at the best of my i: On the best of axar	Year) INJURY — At h. c. (Specify) y knowledge, d mination and/or OF DEATH (ITE	ome, ferm, at earth occurre investigation	M treet, factory	, office	end place, end due ath occured at the	City or Tow to the cause(e) time, data and p	end mann	or as state	ed. e cause(s)	and manner as stated.
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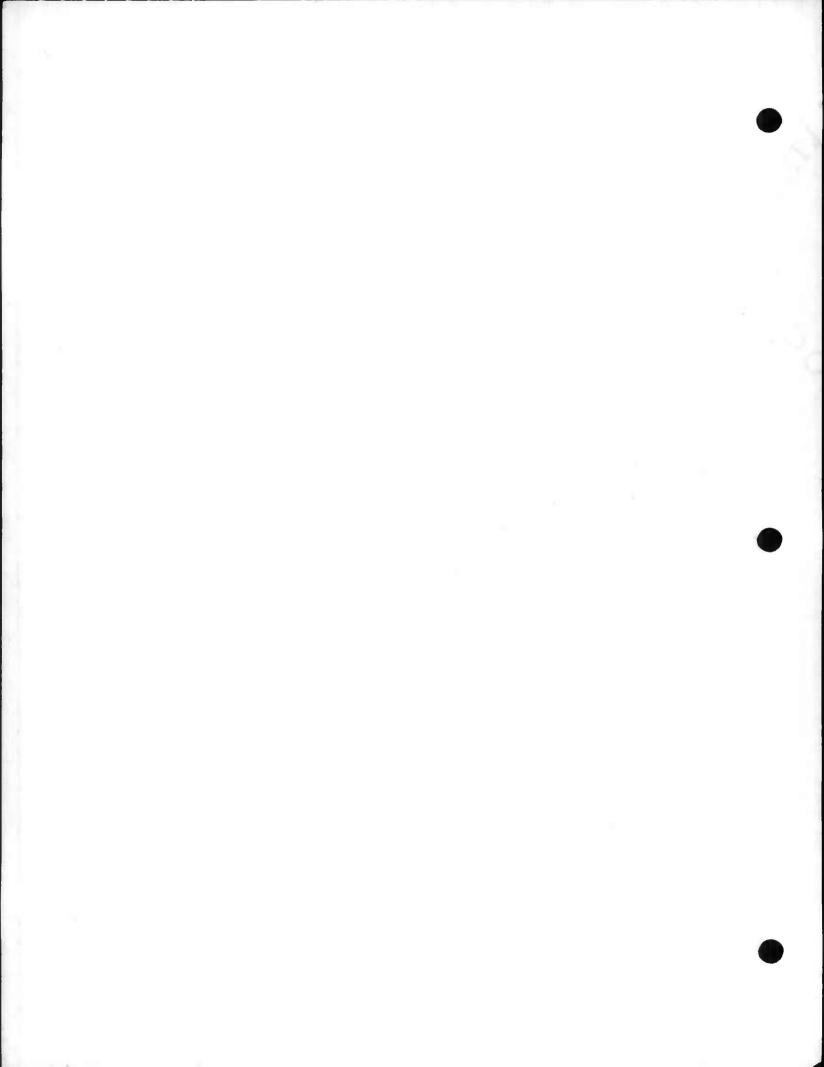
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

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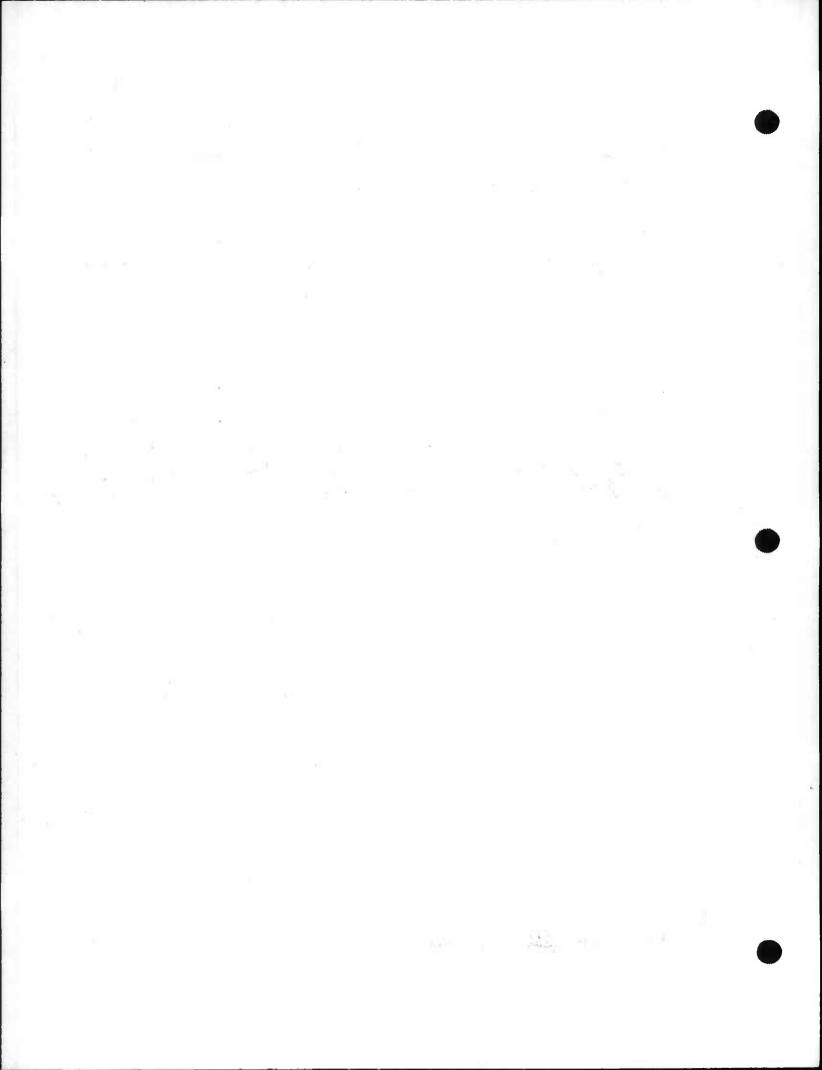
E	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
STRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF MA		RTMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	ATE OF DEATH 3. TIME OF DEAT			
	Yvanne		Rashid	April 26	1995	2041 Pm	
	The second secon	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS, MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Count	IPLACE (State or Foreign	
	386-26-9413 1□ M 2 🖾 F	69 YRS.		Nov. 12, 19	925 Leb	anon	
œ	9a. FACILITY NAME (If not institution, give street and number)		96. CITY, TOWN OR LOCATION OF E	DEATH	9c. COUNTY OF E		
18	Suburban Hospital		Bethesda		Montgon	nery	
DIRECTOR	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCATION			10d. INSIDE CITY	
	MD Montgomery		Bethesda			1X YES 2 □ NO	
FUNERAL	100. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF 1		
N.	5804 Tanglewood Drive 11. MARITAL STATUS 12. WAS DECEDENT B	VER IN II S ADMED		20817	U.S.		
	1 Never Married 2 Married FORCES? 1	YES 2 K NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 X NO Speci	an, Puerto Rican, etc.)	Blac	E — American Indian, k, Whita, atc.	
ВУ	3 Widowed 4 Divorced	ON DATES	TO TES ZIGNO Speci	ny:	Spec	White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S (Give kind of	USUAL OCCUPATION work done during most of working se retired.)	16b. KIND OF BUSIN	NESS/INDUSTRY		
JE.	Elementery/Secondary (0-12) College (1-4 or 5+)	Homema			Own Home		
W.	17. FATHER'S NAME (First, Middle, Last)	Homeme		AME (First, Middle, Malden Su		=	
	Elias Rashid		Miria		imame)		
) BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADORESS (Street and Number or Rural		State, Zip Code)		
٩	Baddia J. Rashid	5804 7	Tanglewood Dr.	Bethesda, M	D 20817	7	
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State		OF DISPOSITION (Name of		TION - City or To		
0	4 Donation 5 Other (Specify) Entombment	Gate or I	Eaven Cemetery	5/1 Silve			
	17	*	22. NAME AND ADDRESS OF FA				
Щ	Vernon Money	unn	/	-		. 20016	
	23. PART I. Enter the diseases, or complications that c shock, or heert fallure. Liet only one cause	eused the deeth. Do a on each line.	not enter the mode of dying, suc	ch as cardiec or respira	itory arrest,	Approximata Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	DisTILL	112574	711.3	0	Onset and Death	
	resulting in death)	AS A CONSEQUENCE OF	nonticy f	HILUFY	e		
z	- Core	NATZY 6	TRIPRY DI	SONGE			
CERTIFICATION	if any, leading to immediate	AS A CONSEQUENCE OF	7 17	00 P3 C			
<u>∑</u>	CAUSE, Enter UNDERLYING CAUSE (Disease or Injury	4uzer		CLEROSI	7		
	that initiated events resulting in death) LAST	AS A CONSEQUENCE OF	F): " " " " " " " " " " " " " " " " " " "				
	d						
4	PART II. Other algnificant conditions contributing to de	eth but not resulting	in the underlying cause given in	Part I. 24s. WAS AN AL		WERE AUTOPSY FINDINGS	
MEDIC				1 □ YES 2		COMPLETION OF CAUSE OF DEATH?	
Æ				_ ´	`	1 YES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSES. WAS CASE REFERRED TO MEDICAL			N 🗆			
Sici	EXAMINER? HOSPITAL:	26. PLACE OF DEAT	OTHER:	or _ 1007			
H	1 Pres 2 NO 1 Inpetient 2 PEI 27. MANNEB OF DEATH 280. DATE OF IN.	R/Outpatient 3 DOA JURY 28b, TIM	4 Nursing Home 5 Residence E OF 28c, INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW INJ	HEY OCCUPED		
ВУ Р	1 Natural 5 Pending (Month, Day,	Year) INJ	WORK? M 1 YES 2 NO	Town Degoting Now Inc	OH OCCORED		
	3 Suicide 6 Could not be	UURY — At home, ferm, s	street, factory, office	281. LOCATION (Street and	d Number or Rural F	Route Number,	
H	4 Homicide determined			City or Town, State)			
COMPLETED	29s. CERTIFIER (Check only	knowledge, death occurre	ed at the time, data and place, and du	to the cause(a) and manne	er as stated.		
O.	OM) 2 MEDICAL EXAMINER: On the beats of many	mellon and/or investigation	n, in my opinion, death occured at the	time, data and place, and s	due to the cause(s) and menner as stated.	
BE C	29h. SIGNATURE AND TITHE OF CONTIFIER	4.	29c. LICENSE NU	MBER	29d. DATE SIGNED	(Month, Day, Yur)	
0	wir. we	ur	MI	01110	14/	11175	
	30- NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	OF OEATH (ITEM 27) (Type,	() DOI 714 1	NID RO	Dias.	1 41 3	
	31. OATE FILEO (Month, Day, Year) 32. REGISTRAR'S	SIGNATURE	U recepta 1 /	int De	MESVI	1 my 208/4	
		sor Randall					
النسب	1000					DHMH-18 Rev 1/89	



DIVISION OF VITAL RECORDS, P.O. BOX 68769

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND !	MENTAL HYGIENE REG. NO.		10010	,	
	1. DECEDENT'S NAME (First, Middle, Last)			JATE 01	DEATH	2. DATE OF DEATH		3, TIME OF DEATH		
	Ada Katherine	Reed.				May 8	1995	/335	м	
	4. SOCIAL SECURITY NUMBER	The second secon		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6 BIRTI	IPLACE (State or Foreign		
- 8	217-28-6312	1 □ M 2] F	76 YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6-26-191	8 Ma	ryland	- 1	
-	9s. FACILITY NAME (If not institution, give s			b. CITY, TOWN	OR LOCATION OF DE	ATH 9c.	COUNTY OF D	EATH		
5	Washington Co	unty Hospi	tal	Hage	rstown		Wash	ington		
EC	10e. STATE 10b. COUNTY			TOWN OR LOCA	TION			10d. INSIDE CITY		
DIRECTOR	Maryland Was		LIMITS?							
	10e. STREET AND NUMBER			Lear S	I. ZIP CODE	10g	. CITIZEN OF V	WHAT COUNTRY?	\dashv	
FUNERAL	12328 Big Spr	ing Road			21722		U.S	.A.	- 1	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED			IIC ORIGIN? (Specify Yes or No	0- 14. RACI	E — Americen Indian, k, White, etc.	\neg	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		2-A NO Specify	n, Puerto Rican, atc.)	Spec	tty:		
	15. DECEDENT'S EDU	CATION	18s. DECEDENT'S US	NAL OCCUPATION				hite		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of wor	rk done during mo retired.)	est of working	16b. KIND OF BUSINES	S/INDUSTRY			
P	8	College (1-4 or 5+)	Manage	er		Ribbon	Compa	ny	- 1	
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Maiden Surna	me)			
BE C	Clarence Gran	t Turner			Bessi	e I. Hart			- 1	
10	19a. INFORMAN'S NAME (Type/Print)					Route Number, City or Town, Star				
	John Henry Re	eed.	123	28 Big	Spring	Rd. Clear	Spri	ng, MD 2	2172	
	201/C METHOD OF DISPOSITION 1 🕀 Burisi 2 🗆 Cremation 3 🗆 Rema	oval from State 20b	PLACE AND DATE OF	DISPOSITION (Na		DATE 20c. LOCATIO	N — City or To	wn, State		
	4 Donation 5 Other (Specify)		Hank cow			11-95 E	Big Po	ol, MD	\Box	
		Thompson Funeral Home, Inc.								
	11/1/90/1//	4-0-		P.0.	Box 31	O Clear Sp	ring.	MD 2172	22	
	23. PART I. Enter the diseases, or o	complications that ceused List only one cause on e	the death. Do not ach line.	enter the mo	de of dying, auct	as cardiac or reepirator	y erreat,	Approximate interval Between		
	IMMEDIATE CAUSE (Final		4	,				Onsat and Dec		
	disease or condition resulting in death)		2 weeks							
	disease or condition resulting in death) a. Ac At Le Kemia 2 wea Due to (or as a consequence of):									
NO N	Sequentielly list conditions, If any, leeding to immediate b									
PA	cause. Enter UNDERLYING	YING								
E	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					1		
CERTIFICATION	resulting in death) LAST	d								
AL C	PART II. Other eignificent condition	a contributing to death b	ut not resulting in	the underlying	cause given in i	Part I. 24s, WAS AN AUTO	PSY 24h	WERE AUTOPSY FINDING	G.S.	
2						PERFORMED?		AVAILABLE PRIDE TO COMPLETION OF CAUSE	-	
						I U YES 2 W N	°	OF DEATH?		
7	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	<u> </u>		1 YES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH							
Sic	1 TES 2 THO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp		THER: Nursing Hom	e 5 🗆 Residence	8 Other (Specify)				
E	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME (URY AT	28d. DESCRIBE HOW INJURY	OCCURED			
B	1 Accident 5 Pending Investigation			M 1 1	YES 2 NO				_	
	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	et, factory, offic	•	28f. LOCATION (Street and Nu City or Town, State)	imber or Rural F	loute Number,		
<u> </u>	an armirin								_	
N P		CIAN: To the best of my knowl								
COMPLETED		R: On the basis of exemination	s end/or investigation,	in my opinion, d	eath occured at the	time, date end pisce, and due	to the csuse(s) and menner as stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	21.	1- 0		29c. LICENSE NUM	BER 29d.		(Month, Day, Year)		
<u>و</u> ا	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED COMPLETE	14.1/.		04(66)	5.9	.95		
					1 0	, 41 /				
	31. DATE FILED (Month, Day, Year)	Clormack 32. REGISTRAR'S SIGN	1799	Hourl	1 Road	Dejerstow	n, MO	21740		
	MAY 1 0 1995	b Davidson Rom	Lil							
السا	1333	and an annual a City	- Charles							



1995

9c. COUNTY OF DEATH

3. TIME OF DEATH

a. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

1 YES 2 1 NO

Approximate

Interval Between

Onset and Death

I. Elinois

Washington

U.S.A

14. RACE — American Indian, Black, White, etc.

spectly: White

3:07 A.

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MPORTANT:

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THE STATE OF THE S	8	3	SUC	E
1	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or rer	TANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medi
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Edward Stanley Ruggiero April 28 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Hear) Aug. 4, IF UNDER 1 YEAR IF UNDER 24 HRS 339-07-9190 DAYS HOURS 1 X M 2 | F 74 1920 VRS Sa. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 14624 Hilltop Rd. DIRECTOR Cascade RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Washington Md. Cascade FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY 14624 Hilltop Rd. 21719 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 U YES 2 X NO Specify: 1 Never Married 2 X Married BY 3 Wildowed 4 Divorced WW II COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5+) 12 Personnel Officer U.S. Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surn Andrea Ruggiero Frances Guarino 76 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 14624 Hillton Rd. Cascade, Md. 21719 Grace L. Ruggiero 9 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Smithsburg Chematory 4-29-95 Smithsburg, Md. examiner 21. PIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 12525 Bradburg Ave. Davis Funeral Home erris avo Smithsburg, Md. 21783 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel the disease or condition ESPIRATUR. ALVES other traumatic event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): TALICNANT CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 shows any injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL PHYSICIAN:

24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 TINO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 DINO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNED OF DEATH 26a. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the time 286. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 294. DATE SHOWED (Morph, Day, Year) WHO COMPLETED CAUSE OF GEATH STEM 275 (Type, Print) MTAETNARD 1190 IMCERSION N MD ST. DATE FILED (MONTH PO

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending phys	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buring	MOE.	the same and the s
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	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
R	CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMEN'	OF H	EALTH AND DEATH	MENT	AL HYGI REG.				
		1. DECEDENT'S NAME (First, Middle, Last	,		-		****			E OF DEATH		WEAR	3. TIME OF DEATH	
		Henry Luther RE							Ac		2η,	1995	0225*	
		4. SOCIAL SECURITY NUMBER		(In yrs. las		IF UNDER	DAYS	IF UNDER 24 HRS.	7. D/(I (Mo	E OF BIRTH)	8. BIRT	HPLACE (State or Foreign	
	ļ	705-12-6277		33	YRS.					ust 5			ryland	
و	=	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Washington County Hospital Hagerstown Washington												
1 8	5	RESIDENCE OF DECEDENT										i G C O II		
o Charles			w shington		10c. CIT								10d, INSIDE CITY LIMITS?	
		10e. STREET AND NUMBER	SHINGLOH			пад	erst	ZIP CODE					1 TYES 2 NO	
FILNEDAL		11104 Lakeside I	Orive				101	21740				USA	WHAT COUNTRY?	
2	5	11. MARITAL STATUS	12. WAS DECEDENT EVER			13.	WAS DEC	ENOENT OF HISPA	NIC ORIG	IN? (Specify	Yes or No-	14. RAC	E - American Indian,	
× ×	- 1	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES		10			cify Cuban, Maxico 2 NO Speci		o Rican, atc.)	Spec	k, White, atc.	
2		15. DECEDENT'S ED	LICATION	16a DE	CEDENT'S	LIGUAL O	COLIBATIO		1.4			1	nite	
		(Specify only highest grad Elementary/Secondary (0-12)		(G	ive kind of a	work done	during mo	st of working	,	Sb. KIND OF	BUSINESS/I	NDUSTRY		
once.		7	0	f	irem	an				rai	lroad			
Once.		17. FATHER'S NAME (First, Middle, Last) David W. Reed						16. MOTHER'S NA)		
ed at		19a. INFORMANT'S NAME (Type/Print)		1.00						. Hul				
TO BY	2	Virginia Alice I	Reed	19	1110	4 La	kesi	de Drive	Ploute Nu	agers	Town, State, .	Zip Code) Md.	21740	
9		20s. METHOD OF DISPOSITION			AND DATE	OF DISPOS	ITION (Na			_	LOCATION			
must		1 X Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify)	00	metery, cre lest	Have	n Cei	mete	ry 4-2	29-9			gerstown, Maryland		
examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME													
		415 E. Wilson Blvd., Hagerstown, Md. 21740												
medical		23. PART I. Enter the diseases, or ahock, or heart feliure	complications that cause	d tha de	ath. Do r	not entar	the mo	da of dying, auc	h aa ca	rdiac or re	apiratory a	arreat,	Approximata	
E E		IMMEDIATE CAUSE (Final disease or condition	1		. 1	. 120							Interval Batween Onset and Dasth	
eut,		resulting in death)	a. DUE TO (OR AS	A CONSE	OUENCE OF	OY M	arra	y con	reg				2/ day	
other traumatic event, the	disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (VILLES (
OI L														
Her tr	. 11	CAUSE (Disease or injury	C	DUE TO (OR AS A CONSEQUENCE OF):										
or oth		that initiated events reaulting in death) LAST	30E 10 (01 X3	A CONSEC	OENCE O).								
Injury,		PART ii Other significant conditions contribution to death but												
		PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Comparison Part II. Part II.												
shows any : MEDIC		700	- Comment							1 TYES	2 NO		OF DEATH?	
60	- и	DID TOBACCO USE CON	TRIBUTE TO CAUSE O	OF DEA	TH YE	SΠI	ио П	UNCERTAIL	N [1 TYES 2 NO	
SICIAN		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		E OF DEAT	H (Check	only one)							
YS.		1 - YES 20 NO	1. Inpetient 2 - ER/Out	patient 3	□ DOA	OTHER 4 Nun		5 - Residence	8 🗆 Ott	er (Specify)				
P. P.		27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		28b. TIM INJ	E OF URY	28c. INJU WO	NY?	26d. D	ESCRIBE HO	W INJURY O	CCURED		
	- 11	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR	Y At ho	me, farm, s	treet, fact	1 U Y	ES 2 NO	281 10	CATION (Stra	net and Numb	ner ne Rumi I	Route Number,	
28 TE	- 11	4 Homicide 8 Could not be	building, atc. (Spe	cify)		,	. ,,		Cit	y or Town, St.	ete)	or riorer r	toda Hombol,	
PLE PLE		29a, CERTIFIER (Check only	SICIAN: To the best of my know	vledge, de	eth occurre	d at the ti	me, data	and place, and due	to the c	puse(a) and i	manner as si	tated.		
MPORTANT: If Item O BE COMPLE			ER: On the basis of axamination										and manner as stated.	
PORTA BE C		296. SIGNATURE AND STILE OF CERTIFIE						29c. LICENSE NUI	WBER	_	29d. D/	ATE SIGNED	(Month, Day, Year)	
TO B		- yost julies	, M.D.					02789	8		▶ 9	4/281	95	
-		30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE		4 27) (Type,	Print)	ni	18 0	He	sector	Le	n		
	-	31. DATE FILED (Month, Day, Year)	32. HEGISTRAR'S SIGN	ATURE:	3	10	ru	1 4	100	1027	4-71	<u> </u>		
		APR 28 199	5 The Street		al-th									

a Physical Lines

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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SIN	s certificate has been signed by the attending physician and completely filled in by th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ren	
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STATE OF MARYLAND /	DEPARTMENT	OF HEALT	H AND	MENTAL	HYGIENE
CF	RTIFICATE	OF DEA	TH		DEC NO

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAI CERTIF	RTMENT OF I	HEALTH AND		IENE . NO.	
)			WARD ROSE				2. DATE OF DEA MONTH, MAY	TH	year 5 0953 m
Pla		4. SOCIAL SECURITY NUMBER 229-36-0360 90. FACILITY NAME (If not institution, give ste	1 × M 2 □ F 6	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN,	7. DATE OF BIRT (Month, Day, M 4-21-1	932	B. BIRTHPLACE (State or Foreign Country) Alexandria. VA
i, 2, 3 should	TOR	Washington County				or Location of D Lgerstown			ington
physician. burial-transit permit. Pages 1, 2,	DIRECTOR		nklin		y, town or local				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
an. transit pem	FUNERAL	557 South Church				1. ZIP CODE 17268		USA	EN OF WHAT COUNTRY?
ing the	ВУ	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAY KOrean	U.S. ARMED 2 NO TES	13. WAS DEC if yes, sp 1 — YES	4. RACE — American Indian, Black, White, etc. Specify: White			
by the hospital or attending be detached for use as the at once.	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of life. Do NOT u	,	ist of working		F BUSINESS/INDU	
by the hospital or I be detached for u at once.	E COMPL	17. FATHER'S NAME (First, Middle, Lest) Chanion J. Rose		'S NAME (First, Middle, Melden Surname)					
5 should	TO BE	190. INFORMANT'S NAME (Type/Print) Nancy M. Rose				and Number or Rural	E. Henry Route Number, City of	or Town, State, Zip C	
leath. Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSITION 1 (X Burlat 2	val from State come	PLACEANDDATE	of disposition (No ther place) nurch Ce	metery	5/6 C	Cascade.	ty or Town, State
2 2 2		21. SIGNATURE OF FUNERAL SERVICE LICE	Borderon		22. NAME A	ND ADDRESS OF FA	cility Grov	e Funera	al Home, Inc. PA 17268
ely fill nation		IMMEDIATE CAUSE (Final	omplications that caused list only one cause on ee	SIS	not enter the mo	de of dying, suc	ch as cerdiac or	respiretory arres	Approximate interval Between Onset and Dasth
th certificate be executed ending physician and con I Hygiene prior to burial, or other traumatic en	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A (/
	MEDICAL C	PART II. Other significant conditions Edd Stage Verd		l a f	In the underlying	g cause given in	PE	IS AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
he law requested has been bept. of n 23 sho		DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL			S NO L	UNCERTAI	N: 🗆		1 YES 2 NO
SICIAN: The certificate h the State if	HYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 11 Inpatient 2 ER/Outpar 28e. DATE OF INJURY	tient 3 DOA			6 Other (Specify		
DING PHYSI After this c death with s marked,	ВУ Р	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) 28e. PLACE OF INJURY	INJ	M 1 URY	PRK? YES 2 NO		OW INJURY OCCU	
OR ATTENDING DIRECTOR: After hours after death item 28 Is ma	ETED	3 Sulcide 6 Could not be determined	building, etc. (Specif	у)			City or Town,	Stete)	Rural Route Number,
보 기 는 두	COMPL	(Check only one) 2 MEDICAL EXAMINER	IAN: To the best of my knowle						Ceuse(e) and menner ee stated.
TO THE HOSPITO TO THE FUNERA De filed within 7 IMPORTANT: I	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER OZA 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAL			29c. LICENSE NUI	MBER 23 3	29d. DATE S	SIGNED (Month, Day, Year)
	-	ELI ROZA MY	WHIHIN	GTON C		17051	rITAL		
		31. DATE FILED (Marth, Day, Year) MAY 0.5, 1995	32 EGISTRAR'S SIGNAT	- Nacht					

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		1 - FOR STATE REGISTRAR	STATE OF MARYL	LAND / DEPAI	RTMENT OF	HEALTH AND	MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)			TOATE OF	DEATH	2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH		
		RAYMOND 4. SOCIAL SECURITY NUMBER	LANGFORD 5. SEX 8. AGE	<i>d</i> - 1.110.1.1		CE	APRIL				
		217-32-3700	1 X M 2 - F	(In yrs. last birthday) 59 YRS.	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)	Coun			
3 should		9a. FACILITY NAME (If not institution, give s	treet and number)	37	Jan. 27,1936 Maryland 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
2	СТОВ	CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT									
Pages 1,	REC	10a. STATE 10b. COUNTY			Y, TOWN OR LOC	ATION			10d. INSIDE CITY		
	🖺	Maryland Calv	ert	Po	rt Repu	blic			1 YES 2 NO		
sit permit.	FUNERAL	1725 Gray's Ro	ad		1	101. ZIP CODE 20676			WHAT COUNTRY?		
020 physician. burial-transit	S	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DE		NIC ORIGIN? (Specify Ye	USA 14. BAC	E — American Indian,		
	BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES		If yes, i	Blac Spec	ck, White, etc.				
r attending use as the	ED	15. DECEDENT'S EDU: (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPAT	JSINESS/INDUSTRY					
21 Balor for u	COMPLET	Elementary/Secondary (0-12)	life. Do NOT u								
AND 2 he hospital detached for	MP	10 17. FATHER'S NAME (First, Middle, Last)		Automoti	ve Engi		Self				
8 8 6 A	В	Frederick	Rice			Mary	AME (First, Middle, Maider	Harri	c		
AR ained should thould	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Ploute Number, City or Tov		5		
be re	2	Faure Rice		P.O.	Box 193	Huntingt	town, MD 20)639			
est gen		20a_METHOD OF DISPOSITION 1	oval from State 201	b. PLACE AND DATE metery, cremetory or C Oung's C	of Disposition (I	Vame of		ocation — city or to ntingtown			
2 2 .		21. SIGNATURE OF FUNERAL SERVICE LIC		oung b		AND ADDRESS OF FA		Funeral			
BALIIN BALIIN ter death. Pag the funeral di wal.		spencer	E. Som	029	1451	Dares Bea	ich Rd. Pri				
in by reme		23. PART I. Enter the diseases, or o shock, or heart fallure.	complicatione that cause List only one ceuse on e	d the death. Do	not enter the m	ode of dying, suc	ch as cardiac or resp	piratory arrest,	Approximata Interval Between		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		iMMEDIATE CAUSE (Finel disease or condition reaulting in death)	aute	hypo	dal A	fordu	Alperone		Onset and Desth		
2 2 2 E	_	Total III good III	DUE TO JOH AS	A CONSEQUENCE O	2110		Aloesse		1975		
UX 667 be executed sician and con rior to burial, traumatic er	CATION	Sequentially list conditions, if any, leeding to immediate DUE TO (OR AS A COMPAGUENCE OF):									
fcate be physician he prior the		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OR)									
Page 1	RTIF	that initiated events resulting in death) LAST	n death) LAST Willow auto Calo Varinh Desere for								
V 0 "9 = 1	S	PART II. Other eignificent condition	a contribution to death I	huit and an initial an							
and and and	CAL	PART II. Other significent condition	a contributing to death t	but not resulting	in the underlyi	ng ceuse given in	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE		
law requires that seen signed lept. of Health a	MEDIC						1 [] YES :	2 PNO	DF DEATH? 1 YES 2 NO		
all His been bept. of 23 sh	ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH Y	S NO	UNCERTAL	N 🗆				
a ge h	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one OTHER:))					
or the	HYS	1 VES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out	patient 3 DOA 28b. Till	4 - Nursing Ho	IJURY AT	8 Other (Specify) 28d. DESCRIBE HOW	IN HIRV OCCURED			
The wife of	BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.	JURY W	YORK?	284. DESCRIBE NOW	INJUNT OCCURED			
TTENDI TTENDI TOR: A after de	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm, ictly)	street, factory, off	ice	261. LOCATION (Street City or Town, State	and Number or Rural i)	Route Number,		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4 1		CIAN: To the best of my know								
THE HOSPITAL THE FUNERAL filed within 72 i	E COM	29b. SIGNATURE AND TILE OF PERPIFIES	R: On the besia of axamination	and or investigate	m, in my opinion,	29c. LICENSE MU		29d. DATE SIGNED			
THE OF THE PORTION	TO B	20 NAME AND ADDRESS OF PERSON AND	een			50 NO	9451	152-	At		
4		30. NAME AND ADDRESS OF PERSON WH	IN S. PEC	RON HD	6106	010 84	1451 NEN AILL VI	10. Formel	ale ful		
_ ′		31. DATE FILED (Month, Day, Year) WAY - 4 1995	32. REGISTRAR'S SIGN	-Rardall							
		1 1000									

3. TIME OF OEATH

11:00

10d. INSIDE CITY

14. RACE — American Indian, Slack, White, atc.

21755

Approximate

Interval Between

Onset and Death

728

24b. WERE AUTOPSY FINDINGS

OF DEATH? 1 YES 2 NO

29d. DATE SIGNEO (Month, Day, Year)

1 5

AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 YES 2 | NO

White

8. BIRTNPLACE (State or Foreign

Maryland

Frederick

10g. CITIZEN OF WHAT COUNTRY?

United States

Specify:

9c. COUNTY OF DEATH

PM

MORE, MARYLAND 21215-0020

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

296. SIGNATURE AND TITLE OF CERTIFIER

08

Kusay

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

BARRICAT

32. REMISTRARY SIGNATURE

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	or
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
	X
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	S
	9

Mae Beatrice Raun May 3 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. (Month, Day, Year, DAYS 1 - M 2 XF 220-26-0576 66 YRS. Jan.6,1929 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR Frederick Frederick Memorial Hospital RESIDENCE OF DECEDENT 10b. COUNTY tos. STATE 10c. CITY, TOWN OR LOCATION Maryland Frederick Frederick permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 228 21701 funeral director, page 5 should be detached for use as the burial-transit Ε. Church St. retained by the hospital or attending physician. tt. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 MO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried B 3 Widowed 4 Divorced ETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 7th Business Propretor Machine Shop ---17. FATHER'S NAME (First, Middle, Last) ta. MOTHER'S NAME (First, Middle, Maiden Surname) F ADAM LAWRENCE KEENEY, SR. CORA MAE CLEM KEENEY BE notified 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carol Smith 3502-B Fry Rd./ Jefferson, Maryland must be 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Mount Olivet Cemetery 4 Donation 5 Other (Specify) 5-6 Frederick, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home Saymond 1621 Opossumtown Pike/Frederick, Md. 21702 completely filled in by the rial, cremation, or removal. medical 23. PART 1. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, mock, or heart fallure. Liet only one cause on each line. 0 IMMEDIATE CAUSE (Final the disease or condition traumatic event, resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) hysician and com prior to burial, CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disesse or injury or other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY n signed by the Health and N PERFORMED? shows any 1 TYES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) Item certificate ? HOSPITAL OTHER: 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCUREO marked, this (1 Natural 5 Pending м 1 YES 2 NO After BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 69 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be L DIRECTOR: 2 hours after 4 Homicide determined ᄪ 29s. CERTIFIER (Check only CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner ea stated. COMPL TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, end due to the ceuse(a) and manner es stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2. DATE OF DEATH

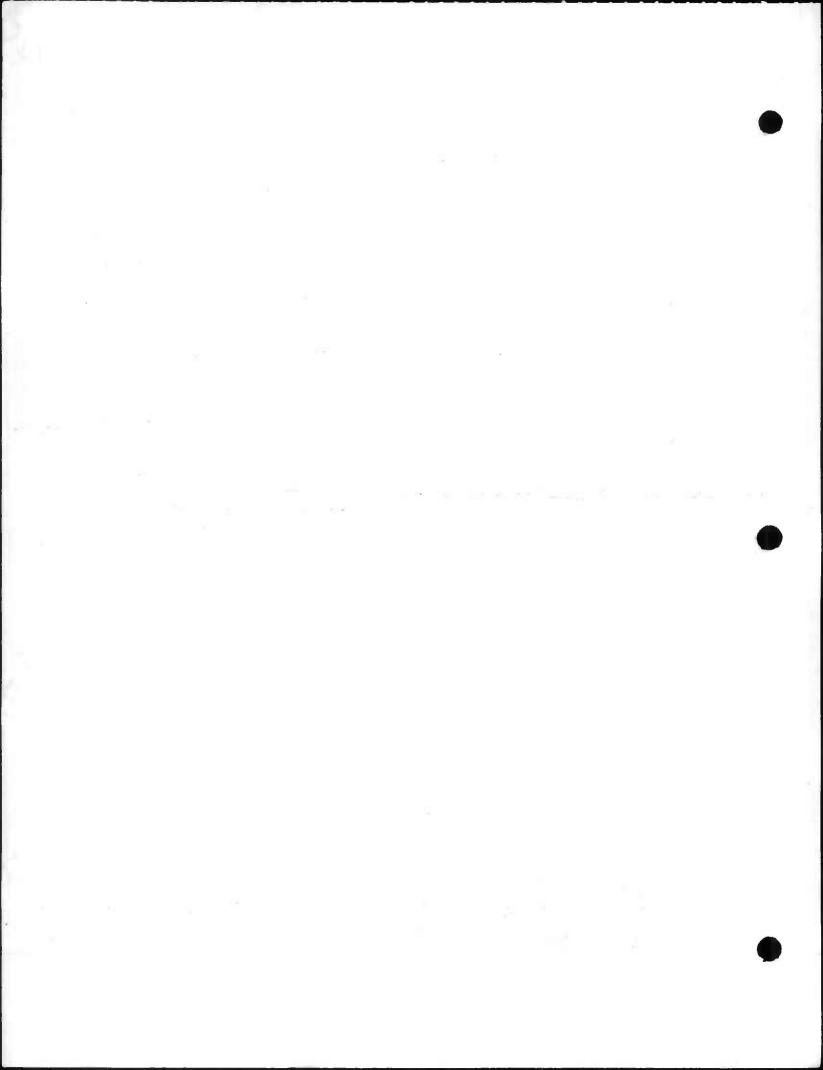
29c. LICENSE NUMBER

310 w 9th street Galancle

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DNMH-18 Rev 1/89



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		FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL HYGIEN			, •
		1. DECEDENT'S NAME (First, Middle, Last)		OLITTI	IONIE OI	DEATH	2. DATE OF DEATH 3. TIME OF DEATH			
		Viola	77 d annud and a	DEN	CDDDG		MONTH D		'EAR	
			Virginia SEX 6 AGE (ISBERG			1995	1:57 P.	
			The second	In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreig Country)	2n
10		3//-UL-020/	□ M ² X ^F 82	YRS.			Dec. 31,	1912	Maryland	
3 should		9e. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOWN	OR LOCATION OF DE			OF DEATH	
	18	Northampton Mane	or Mursing	Home	Er	ederick			Prodovi al-	
physician. burial-transit permit. Pages 1, 2,	DIRECTOR	Northamoton Mand	ZI MULSING	HOME	FL	edelick			Frederick	
ges	1	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY	
ی	<u>a</u>	Maryland Frede	erick		Fred	erick			1X YES 2 NO)
E	7	10e. STREET AND NUMBER				of. ZIP CODE		10g, CITIZE	N OF WHAT COUNTRY?	
St. D	FUNERAL	200 East 16th Stree	o+				21701		U.S.A.	
ian. tran	Z		. WAS DECEDENT EVER IN	III C ADMED	1 40 1110 00					
physician. burial-trar	교	1 Never Married 2 Merried	FORCES? 1 TYES	2 NO			NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	e or No 14	. RACE American Indian, Black, White, etc.	
	B₹	3 🖫 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DA	TES	1 🗀 YE	S 2 NO Specif	y:		Specify: White	
attending se as the	ED	15. DECEDENT'S EDUCATI	on I							
te 8	뿌	(Specify only highest grade com		(Give kind of v	work done during m		16b. KIND OF BU	SINESS/INDUS	TRY	
for for	LET	Elementary/Secondary (0-12)	ollege (1-4 or 5 +)	life. Do NOT us	ie retired.)					
ched	F	11		Sales r	epresen	tative	Departm	ment St	tore	
the hospital or detached for u	COMP	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle, Meiden	Sumame)		
3 % W	ш	Eugene Harper				Leora	Culler			
5 should	8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or Tow	m. State Zin Co	vrle)	
5 W 5	임	James C. Fisher, Jr								
ay be		20a. METHOD OF DISPOSITION					ve, Woodbr			
E y B		1, Buriel 2 ☐ Cremation 3 ☐ Removal	1rom State 20b.	PLACE AND DATE Of etery, cremetory or of	ther place)				y or Town, State	
director, ler must		4 ☐ Other (Specify)	Fort 1	Lincoln	Cemeter	y May	6. 1995 F	Brentwo	ood, Marylan	d.
funeral of transmeral of trans		21. SIGNATURE OF FUNERAL SERVICE LICENS	b .V .							
after death. Page 6 by the funeral direct moval.	- 3	Nubert C.C.	Instord.	M00021			Basford Fur			
after by the emoval.		23. PART I. Enter the diseesea, or com	plication that course		106	East Chu	rch St , F	reder		
in the		shock, Dr heert fallure. List	only one cause on ea	ich line.	ot enter the m	ode of dying, suc	n ss cerdiac or respi	Iratory srres	t, Approximats interval Betw	
filled or s		IMMEDIATE CAUSE (Finsi							Onset and De	
		disease or condition resulting in death)	Cenhr	mal	~ 10-	zint T			4-6w	As.
completely ial, cremati			DUE TO (OR AS A	CONSEQUENCE OF						
and con o burial,	z		Arenos	which	Comp. 4	maly	Dun.		2 Den	4
	ERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF					-	,
physician ne prior t	¥	if sny, leading to immediate cause. Enter UNDERLYING							İ	
ng physiene p	윤	CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE OF	n.					-
nding Hygie or oth	E	that initiated events resulting in desth) LAST			,.				i	
death certificate attending physiene pri ental Hygiene pri iry, or other to	빙	d								
		PART II. Other significent conditions co	ontributing to deeth be	ut not resulting i	in the underivin	g cause given in	Part I. 24s WAS AN	ALITOPSV	24b. WERE AUTOPSY FINDIN	MOR
ed by the thrand any in	MEDICA	9	in and				PERFOR	RMED?	AVAILABLE PRIOR TO	
gned gath	□			~			1 YES 2	- CANO	OF DEATH?	5E
een sign of Heal	M								1 TYES 2 NO	
has been signed by Dept. of Health and a 23 shows any it	ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YE	S NO	UNCERTAI	V 🗆		-	
I. The Laster has State De litem 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEAT	H (Check only one,					
SiCIAN: The certificate h the State 1d, or item	S		OSPITAL: Inpetient 2 ER/Outpe	ntient 3 🗆 DOA	OTHER:	ne 5 🗆 Residence	8 Other (Specify)			
SICIA certi	РНҮ	27. MANNER OF DEATH	28e. DATE OF INJURY	JURY AT	28d. DESCRIBE HOW I	NJURY OCCUR	DED.	-		
NG PHYS ther this cath with marked,		1 Netural 5 Pending	YES 2 NO			7 In 10°				
After death	BY	2 Accident Investigation	ARA BLACE OF IN HIRW	4.1.						
TTEND TTOR: / after d	ED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At nome, rarm, s ify)	Breet, Tectory, offic	DE .	281. LOCATION (Street of City or Town, State)	and Number or	Rural Route Number,	
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	<u></u>	- January Getermined								
DIRECT Phours	17	290. CERTIFIER (Check only	: To the best of my knowle	edge, death occurre	d et the time, date	e end place, and due	to the cause(a) and mar	nner se stated		
PITAL ERAL 72	COMPL								euse(e) end manner se stated	,
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the THE FUNERAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept. of Health and M PORTANT: If Item 28 is marked, or Item 23 shows any inje	8		A -		, and appropriate			~ uve to the C	(4) 4173 11819141 28 212100	u.
THE F	8	296. SIGNATURE AND TITLE OF CERTIFIER	· Many			29c. LICENSE NUM		29d, DATE S	GNED (Month, Day, Year)	
10 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0					0-1	8171	Ma	v 4, 1995	
		30 NAME AND ADDRESS OF PERSON WHO CO								

A Street Str

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BOX 68760,	NTTENDING BHYCICIAN: The law remises that the death partitions he executed within a
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P.O.	Partif
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$\tilde{\Box}$	440
OR	that
REC	rachinge
7	ALC:
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DIVISION OF VITAL RECORDS,	PHYSICIAN- 1
VISION	ATTENDING
5	a
_	THE HOSPITAL OR AT
	H

JOHN T. RIGGIN, III. 4. SOOL SCIENTY MANAGE 214-42-1623 X[w 2 p] E. Ade pring to promote the promote that the promote th		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH											
THE STATE OF DESCRIPTION OF LOCATION OF DEATH WORK (First Indication of the Committee of th		4 SOCIAL SECURITY NUMBER		April 29, 1995			6:30						
THE PROPERTY OF PR		214-42-1623	1X M 2 🗆 F 51		MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Cour			ountry)			
13.19 Grays Corner Road 13.19 Grays Corner Road 11. MARINEL STATUS 11. More Married 2 Married 2 Married 3 Married 1 12. MAS DECEMENT FYER IN U.S. AMADD 12. MAS DECEMENT SECUCION 13. MAS DECEMENT SECUCION 14. MACE - American Indian, Purion Risen, etc.) 14. MACE - American Indian, Purion Risen, etc.) 15. MORE DECEMENT SECUCION 16. DECEMENT SECUCION	TOR	11319 Grays Co					DEATN						
13.19 Grays Corner Road 13.19 Grays Corner Road 11. MARINEL STATUS 11. More Married 2 Married 2 Married 3 Married 1 12. MAS DECEMENT FYER IN U.S. AMADD 12. MAS DECEMENT SECUCION 13. MAS DECEMENT SECUCION 14. MACE - American Indian, Purion Risen, etc.) 14. MACE - American Indian, Purion Risen, etc.) 15. MORE DECEMENT SECUCION 16. DECEMENT SECUCION	DIREC	10a. STATE 10b. COUN		10c. CITY						LIMITS?			
TYES, ONE WAS OR DOUGLES Widoward & Stored Control TYES OF WAS OR DATES			rner Road		10				OF WHAT COUNTRY?				
15. DECEMBER BOULDING 150 College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. College (14 or 5 +) 16. DECEMBER SUBJUL OCCUPATION 150. DECEMBER SUBJUL OC		11. MARITAL STATUS 1 Nover Married 2 Merried	12. WAS DECEDENT EVER IN U.S., FORCES? 1 YES 2	RMED NO	If yes, sp	CENDENT OF HISPA	an, Puerto Ric	(Specify Yes or an, etc.)	No- 14. F	AACE — American Indian Black, Whita, atc.			
John Thomas Riggin, Jr. Sequentially list conditions and least of the state of t		15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)	(e completed)	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY					White				
The mailting address of Part The Mailting Address of Part	u	17. FATNER'S NAME (First, Middle, Last)	iggin, Jr.				AME (First, Mid	dle, Maiden Su	mame)	services			
A Donation S Other (Speech) Asbury Cemetery 5/1/95 Crisfield, MD	00	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)											
22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, individual individu		20a. METHOD OF DISPOSITION Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) DATE 20c. LOCATION — City or Town,											
28. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arreat, interval Between abock, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Final diseases or condition as or conditions) But TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Cause. Enter INDERLYING CAUSE (Disease or injury of the death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE		Robert H. Bradshaw Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817											
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WRRE AUTOPSY PERFORMED? 1		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metastatic Hall & Neck Conn.											
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1	TIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
27. MANNER OF DEATN Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 2 Could not be determined 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY — At home, farm, street, factory, office 2 Sea. PLACE OF INJURY AT WORK?	HILLEA	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSI	EOUENCE OF)	ı:								
27. MANNER OF DEATN Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office 28l. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the baela of assertion and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TIME OF SETTIFIES 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day,	MEDICAL	cause. Enter UNDERLYING CAUSE (Dissess or injury that initiated events resulting in death) LAST	d			g cause given in		PERFORME	07	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATN?			
28e. PLACE OF INJURY — At home, farm, street, factory, office 29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TITLE OF CERTIFIER 29e. SIGNATURE AND TITLE OF CERTIFIER 29e. LICENSE NUMBER	MEDICAL	cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	dns contributing to death but not	resulting in	o the underlying 26. PL OTHER:	ACE OF DEATH (Ch	eck only one)	PERFORME	07	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATN?			
296. SIGNATURE ARE TITLE OF DESTIFES 29d. DATE SIGNED (Month, Day, Year)	PHYSICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Natural 5 Pending	d	resulting in	26. PL OTHER: 4 Nursing Nom OF 28c. INJI	ACE OF DEATN (Ch	eck only one) 6 Other (S	PERFORME VES Poecity)	NO NO	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO			
296. SIGNATURE AND TITLE OF DETITIFIES 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 296. SIGNATURE AND TITLE OF DETITIFIES 296. DATE SIGNED (Month, Day, Year)	ED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant conditio 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Netural 5 Pending Investigation 3 Suicide 8 Could not be	HOSPITAL: 1 Inpetient 2 ER/Outpetient 28a. DATE OF INJURY 28a. PLACE OF INJURY — At h	resulting in	26. PL OTHER: 4 Nursing Nom Of 28c. INJ! WO 1 N	ACE OF DEATN (Ch. Rasidence WAT RKY TES 2 \(\sum_{NO} \)	6 Other (S 28d. DESCR	PERFORME YES Peciliy) BE HOW INJU	NO NO	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATIN? 1 YES 2 NO			
	OMFLETED BY PHISICIAN: MEDICAL	CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpatient 2 ER/Outpatient 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At building, etc. (Specify)	3 DOA 28b. TIME INJU	26. PL OTHER: 4 Nursing Nom OF 28c. Null RY WO M 1 \cdot \cdo	ACE OF DEATN (Ch	6 Other (S 28d. DESCR 28l. LOCATIC City or 1	pecify) IBE HOW INJU ON (Street and own, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO			

JOHN 2. HIBBIN, ILL. APRIL 29, 1995 6:30 A

211-2-1623 % 51 Aug. 14, 1443 Mary and

(1319 Grays Jorner Road (nome) eriin wordester

Ber in .aryland Worcester

11319 Grays Cor er koad 71511 USA

93100

Lannena ce serv cer TOUT h.s. granuate

Katherine Labarre John Thomas Kiggin, Jr.

Katherine ... Riggin (mother) 3234 Boone Wood - Crisfield, ...D 21517

Asbury Cemetery 5/1/95 Crisfield, No

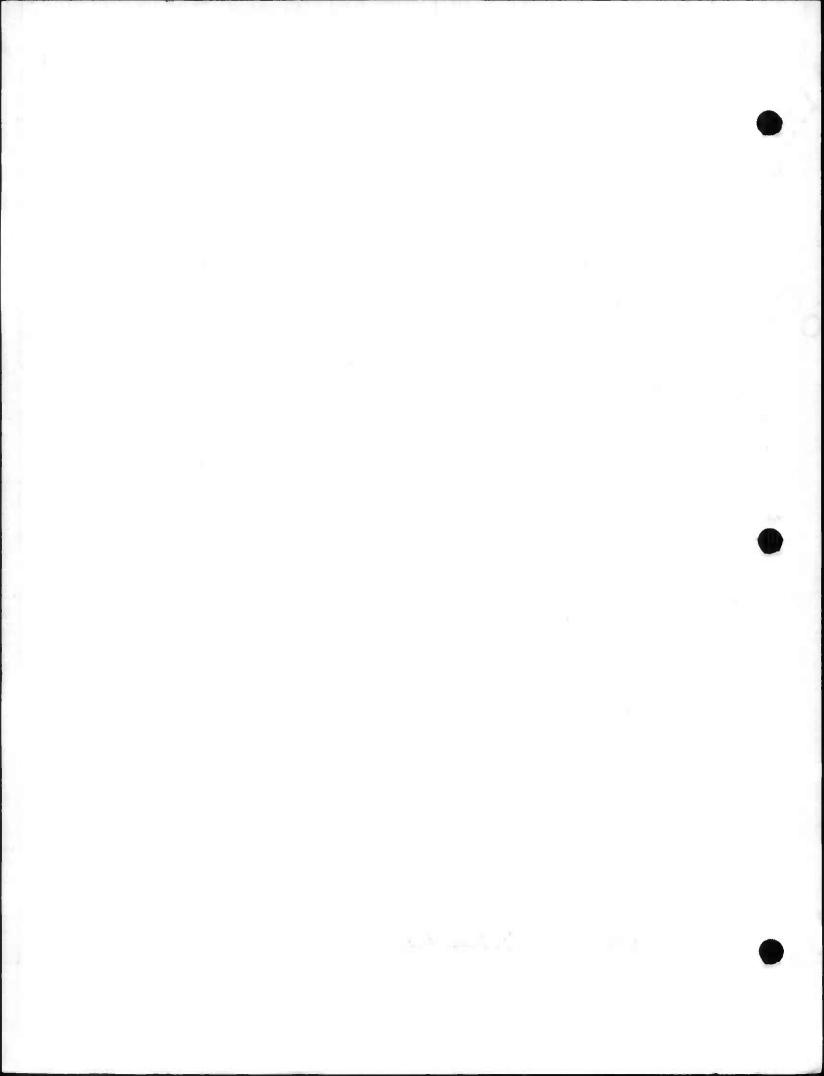
Acobert 1. Bradshaw & Sons Funeral None 306 %. Jain St. - Cristiald, 306 %. .ain St. - Crisfield, .D 21817

DF VITAL RECORDS, P.O. BOX 68760.	within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Memal Hygiene prior to burial, cremation, or removal.	, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 687	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the - be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other traumatic e	

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATN
	ALBERT	- R:	+ ALL	ALBERT E	. RY	ALL				4 26	199	YEAR 5	6:40 PM
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	277	S. BIRTI	IPLACE (State or Foreign
	212-12-323	3	1 🔯 M 2 🗌 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	7- 1- 1910 Md.		ny)	
	Se. FACILITY NAME (If not institution, give street and number)					96. CITY	Db. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					PEATH	
DIRECTOR	Waterview Health Care Center					Sa	lish	oury			Wi	comi	co
낊	10e. STATE	10b. COUNTY	1		10c. CITY	r, TOWN	OR LOCA	ATION					10d. INSIDE CITY
# I	Md.	Wicon	mico		I	LIMITS?					LIMITS?		
A	10e. STREET AND NUMBER					101, ZIP CODE 10g. CITIZEN					IZEN OF	WHAT COUNTRY?	
ER	102 S. Came	102 S. Camden Ave.						21	826		USA		
FUNERAL	11. MARITAL STATUS			T EVER IN U.S. ARI		13.	WAS DE	CENDENT C	F HISPAN	IIC ORIGIN? (Specify Yea	or No-	14. RAC	E — American Indian,
BYF	1 Never Married 2 3 Widowed 4 X Divo		IF YES, GIVE V		U		1 Yes, s	S 2 X NO	n, Mexica Specify	n, Puarto Rican, atc.)			k, White, etc. Wy.White
						1							Wnite
	(Specify onl	EDENT'S EDUC y highest grade		(Gr	CEDENT'S we kind of w Do NOT use	rork done	during m	ION lost of working	ng	16b. KIND OF BUS	INESS/INI	DUSTRY	
1 2	Elementary/Secondary (t)-12)	College (1-4 or 5	+)	m Lat	- '				Formers	c n	1 4-	T
COMPLETED	17. FATNER'S NAME (First, M	liddle, Last)		ral	ш цац	ore	I	18 MOT	NEO'S NA	ME (First, Middle, Meiden		lant	ers Inc.
Ö	Robert Rya	11								e (Maiden		orm)	Dv211
BE	19a. INFORMANT'S NAME (196	MAILING	ADDRES	S (Street			Toute Number, City or Town			Nyali
2	Kathy Hill				102 5	S. C	amde	en Av	e. F	ruitland,	Md.	2182	6
	20a. METHOD OF DISPOSIT		comi tenen State	20b. PLACEA	NDDATEO	FDISPOS	SITION (N			DATE 20c. LO			
	4 Donation 5 Other	(Specify)		oemetery, crer	Fello	ows							
1	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE //	1. ,	22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc.								
	William	- M	Llo	1						-		6	
	23. PART I. Enter the diseases, or complications that paused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate												
	interval Between Onset and Death												
ĺ	disease or condition	→	MET	4STATIC		94	CE	R C	F	COLON.			2120000
	disease or condition resulting in death) a. METASPATIC CAULER OF COION. Due to (or as a consequence of):												
Z	Sequentially liet conditions, ff any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):									2 Duys.			
Ĕ	if any, leading to imme cause. Enter UNDERLY	diate	DUE TO	(OR AS A CONSEC	UENCE OF):		1		4			7.0.
CERTIFICATION	CAUSE (Disease or Inju	iry 4	c. DUE TO	COB AS A CONSEC	OCU	107	ace	Tuge	ruc	nou,			+ reeys
Ē		if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST AUTE Myoluwial lyauution, 7 Druys Due to (on as a consequence of):								i ' [
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MEDICAL	PART II. Other aignifica	endition	a contributing to	death but not re	euiting i	n the u	nderiyir	ng cause (given in	Part i. 24a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
6					·					1 YES 2	DING		COMPLETION OF CAUSE OF DEATH?
¥	DID TODAGE	O HEE	COLUMNIA I										1 _ YES 2 _ NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO												
ᅙ	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	-2714V C		OTHE		PLACE OF D	EATH (Ch	eck only one)			
₹ ¥	1 YES NO		1 _ Inpatient 2 _	ER/Outpatient 3	28b. TIME	_			sidence	8 Other (Specify)		****	
	Netural 5	Pending	(Month, D	lay, Year)	INJ		W	JURY AT ORK? YES 2	- NO	28d. DESCRIBE HOW II	NJURY OC	CURED	
BY	3 Culette	Investigation	28a. PLACE C	F INJURY — At hor	ne, tarm, s	treet, fact			110	281. LOCATION (Street a	nd Numbe	c or Burnt	Route Number
	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At hom building, etc. (Specify)						,			City or Town, State)		or Harer	Totto Harrison,
Ë	29a. CERTIFIER CERTIFVING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.												
COMPLETED	COMBON ONLY												i) and manner ea stated.
	2 MEDICAL EXAMINER: On the basis of examinstion end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)												
8	(ecu uh	N84	ea b	MID				7	320	14	DAT	H177	(Month, Day, Year)
일	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	OF OF DEATH (ITEM	1 27) (<i>Type</i> ,	Print)						1-1	
	MAHESH MI	DONDE	4. M.D.	547 E	RIVE	vsin	E	PRIGA	= Sa	er o broen	M	0 1	1801
	31. DATE FILED (Month, Day,	Year)	32. BEGISTRA	R'S SIGNATURE						eles browy	1.16		
	MAY	1 1995	Jalind	Murlson Ray	Wall								
											_		DUMAN 48 Bay 480



etained by the hospital or attending physician. Should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ea hours after death. Page 6 may be re	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be no	l
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١	EX	E FU	IM P	FITA	l
	F	Ξ	Jek L	0	
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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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that initiated events

27. MANNER OF DEATH

6 Could not be

1 Netural 2 Accident

3 Sulctda

4 Homicide

											9	5	155	49
	1 - STATE REGISTRAR	STATE OF M	ARYLAND /		RTMENT					YGIEN EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) Carolyn Elizabet								2. DATE OF D	EATH DA		YEAR 95	3. TIME OF 0	EATH Å M
	579-88-5452					1 YEAR DAYS	IF UNDER	7. DATE OF BIRTH (Month, Day, Year 7			8. BIRTHPLACE (State or Country) Wash. D.C.			
TOR	Packet Name (If not institution, give so Laurel Regional H				aure	R LOCATIO	ON OF DE	ATH			nty of D	George	's	
DIRECTOR	10a. STATE 10b. COUNTY	e George'	s		aure		ION						10d. INSIDE C LIMITS? 1 X YES 2	7.1
FUNERAL	7710 Hyacinth Court					101	ZIP CODE					CITIZEN OF WHAT COUNTRY? USA		
COMPLETED BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MO IF YES, GIVE WAR OR DATES					If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:					Speci	RACE — American Indian, Black, Whita, etc. Specify: Lack		
		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Secondary (0-12) College (1-4 or 5 +) 4 V°S •				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Examiner					Health PLus			
BE COM	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) INathaniel M. Adams, Jr. Catherine Everett								8					
TO B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING A						NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyacinth Ct. Laurel, Md. 20707							
	20a. METHOO OF DISPOSITION 1 Neurial 2 Cremation 3 Remote 4 Donation 8 Other (Specify)		206. PLACE A cametery, cren Harmo	natory or o	thar place)	ial	PArk					City or To		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home 4217 9th. St. N.W. Wash. D.C. 2001								0011					
	23. PART (/Entar the diseases, or c shock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition	complications that List only one cause	caused the dec se on each line.	oth. Do r	not enter	the mo	da of dyir	ng, auch	aa cardiec (or reapli	ratory an	rest,	Approx	imata Between and Death
_	resulting in death)	DUE TO	OR AS A CONSEO	UENCE O	F):	me	her	2	en	Sol	an			
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CONSECU	DENCE OF	hi ex	l.	tul	50	Ovar	in	ass	27		

resulting in death) LAST PART II. Other algoriticant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

DUE TO (OR AS A CONSEQUENCE OF):

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? YES 2 | NO OF DEATH? 1 TES 3 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only of HOSPITAL: 1 TES TO NO

OTHER:
4 | Nursing Home | 5 | Raeldenca | 8 | Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK?

28a. PLACE OF INJURY — At home, farm, atreet, factory, offi building, stc. (Specify)

YES 2 NO	
ca	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. (Check only one)

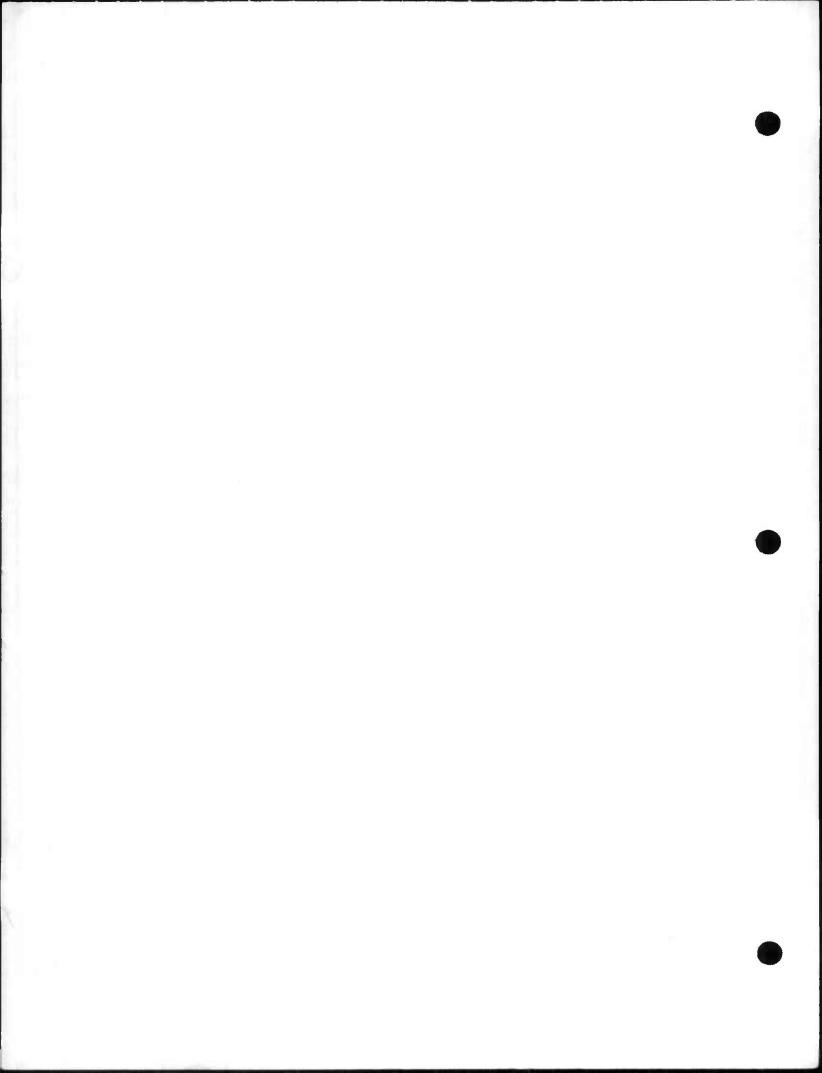
2 MEGICAL EXAMINER:	On the basis of axamination and/or investigati	on, in my opinion, death occured a	t the time, data and place	, and due to the cause(a) and manner as stated.
SIGNATURE AND TITLE OF PERTIFIER		29c, LICENS	NUMBER 1	29d. DATE SIGNED (Month, Day, Year)

1		7	-	300	100	and the same	No.		-					
O. PAME	ANO	ADDRESS	OF	PERSON	WHO	COMPL	ETED	CAUSE	OF	OEATH	(ITEM	27)	(Туре,	Print)
8 /		^												

Dura r	NAMODESENS	Mo
MAY 4 1995	Jahr Dawelon Randell	

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lo	32 REGISTRAR'S SIGNATURE



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BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	rufficate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to nours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the in the first within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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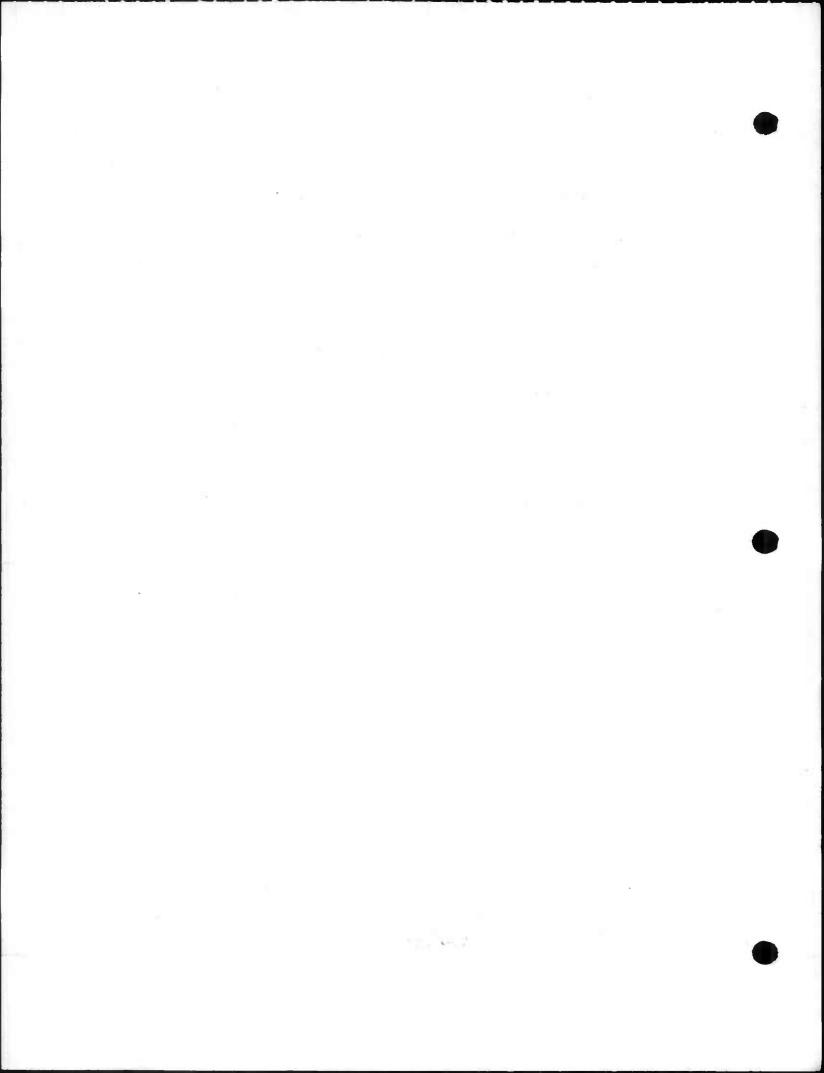
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ELSIE TALBERT SHELTON April 1995 7:35 A.M 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 M 2 X F 043-38-1131 89 YRS. June 2, 1905 Washington, DC 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Collington Episcopal Life Care Center Mitchellville Prince George's 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Mitchellville 1 X YES 2 NO 10s STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10450 Lottsford Road 20721 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— II yes, specify Cuban, Mexicen, Puerto Rican, etc.)
1 □ YES 2 ☒ NO Specify: LTb i to 1 Never Married 2 Married 3 📉 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 166 KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5 +) 4 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edgar Hume Talbert Daisy Emily Hodgson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Shelton M150 Tenbytowne, Delran, New Jersey 08075 20a. METHOD OF DISPOSITION
1 ☐ Burlet 2 🖄 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory -5/01/95 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Entar tha diseases, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feilure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) d stage Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, landing to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \sideset Uncertain \square 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER:
4 Signaling Home 5 Residence 6 Other (Specify) 1 | YES 2 | NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Historial
2 Accident 5 Pending t YES 2 NO 28e. PLACE OF INJURY — At home, lerm, atreet, lectory, office building, etc. (Specify) 3 Suicide 261, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 84 Maso 037734 ne mp 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Stephanie Trifoglio, M.D. 7500 Greenway Center Dr. Greenbelt, MD20770

AS RECENTIANIS SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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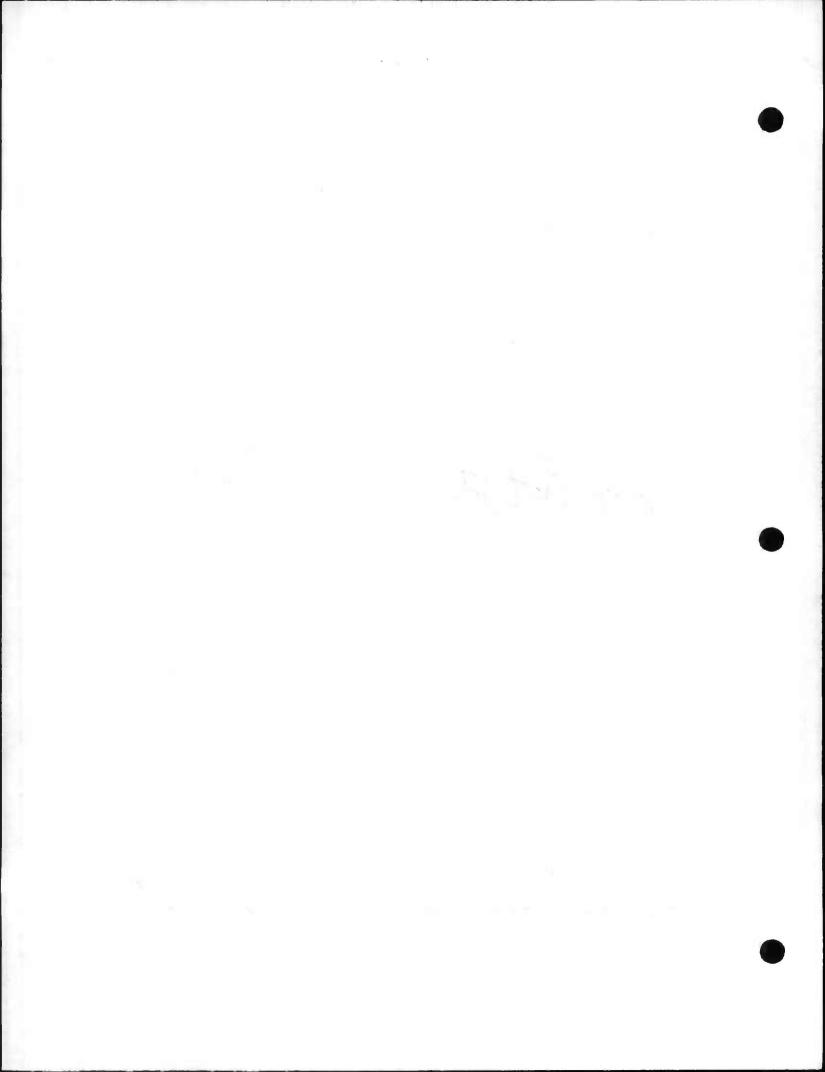
Vincent Chen 9131 Piscataway Road,

32. REGISTRAR'S SIGNATURE
JULY D'AUXILIANT RENEALL

31. DATE FILED MAY 1 100 1995

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	FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR	RTMENT	OF H	EALTH	AND I	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF D MONTH											3. TIME OF DEATH		
	Jack Frederick Schulz May 3							3,199	5	YEAR	2:15 P.M.			
-	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		6. BIRTI	HPLACE (State or Foreign	
	579-24-4792	1 🔯 M 2 🗆 F	70	YRS.	MONTHS	DAYS	HOURS	MIN.	Marc	h 1, 1	925	Pen	msylvania	
	Se. FACILITY NAME (If not institution, give			9b. CITY,	TOWN C	R LOCATIO	ON OF DE	_			INTY OF D	_		
S S	Southern Maryland Hospital Center Clinton										Pr	ince	George's	
DIRECTOR	RESIDENCE OF DECEDENT										Tiloc	ocorge s		
2	10a. STATE 10b. COUNT	•			ry, town o		ION						10d. INSIDE CITY LIMITS?	
	Maryland Char				Waldo	orf							1 TES 2 NO	
FUNERAL	100. STREET AND NUMBER 2982 Hickory Va	llev Driv	<i>r</i> e			101	ZIP CODE	2060	1		10g. CI1	TIZEN OF	WHAT COUNTRY?	
Ü								2000	1		Uni	ted .	States	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES?	ECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPAN 14 yes, specify Cuban, Mexical					NIC ORIGI	Y? (Specify Yes	or No-	14. RAC	E American Indian, k, White, etc.		
ВУ	3 Widowed 4 Divorced	WOY IN WES	World War II 1 yes 2				3 2 NO Specify:					Specify:		
	15. DECEDENT'S EDU												White	
COMPLETED	(Specify only highest grade	completed)	/G	ive kind of	work done of se retired.)	during mo	N st of workin	g	166	. KIND OF BU	SINESS/IN	DUSTRY		
J.	Elementary/Secondary (0-12)	College (1-4 or 5 -	•)				المعاما		- [T	/	_ 7		
N N	17. FATHER'S NAME (First, Middle, Last)		Da.	res .	Repre	sen						Indi	ustry Produc	
		ahul a								Middle, Maiden	Surname)			
BE	Jack Frederick Schulz Frances Herdman													
9	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Nymber, City or Town, State 2982 Hickory Valley Drive, Waldon													
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	20a, METHOD OF DISPOSITION XX Burlel 2 Cremation 3 Ran	noval from State	20b. PLACE A cemetery, cre	MRID DATE	OF DISPOSI	ITION (Na	me of		DAT	E 20c. LO	CATION -	City or To	own, State	
1	4 Donation 5 Specify) 21. SIGNATUME OF FUNERAL SERVICE LI	enimen .	Cedar	H11.	I Cen	ete	cy Ma	ay 6	,199	5 Sui	tland	d, Ma	aryland	
	A. SHARAJONE OF PURENAL SERVICE OF	JA C	1		22. 1	NAME AN	D ADDRES	SS OF FA	CILITY	ee Fun	eral	Home	e,Inc 6633	
	Loun 1		A							_			on, Md 20735	
1 1											Approximata			
	immediate cause (Fine)	List only one cau	ise on each line										Interval Between Onset and Death	
	disease or condition	1.1	ETASTA	0.0	01	YE	7							
	reaulting in death)		(OR AS A CONSEC			100							2-3 weeks	
2														
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	DUENCE O	F):									
₹ I	cause. Enter UNDERLYING													
Ē	CAUSE (Disease or injury that initiated eventa	DUE TO	(OR AS A CONSEC	DUENCE O	F):									
12	resulting in death) LAST	d.												
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N.	PART ii. Other aignificant condition						_	_		24s. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
ă	HEAD AND NEC	L CANC	ER, CO	ison	ARY	ARTI	SRY	DISE	456	1 - YES 2	NO		OMPLETION OF CAUSE OF DEATH?	
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ż	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YI	ES 🗆 N	10 🗆	UNC	ERTAIN	V 🗆					
동	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check o									
S	1 TES 2 NO	1 Inpetient 2	ER/Outpatient 3	□ DOA	4 Num		5 🗆 Re:	sidence	6 🗆 Othe	r (Specify)				
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28e. DATE OF (Month, Da		28b. TIM	IE OF	28c. INJ	JRY AT		28d. DES	CRIBE HOW I	NJURY OC	CURED		
BY	1. Natural 5 Pending 2 Accident Investigation	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,000	M		ES 2	NO						
	3 Suicide 6 Could not be	28e. PLACE O building.	F INJURY — At horate. (Specify)	me, ferm,	street, facto	ory, office	,			ATION (Street I		r or Rural I	Route Number,	
H	4 Homicide determined	_ anang,	(-pow.))						Gity	or Town, Stete)				
COMPLETED	29e. CERTIFIER	ICIAN: To the best of	my knowledge de	nth occur	ed at the si	me, date	and place	and due	to the ac-	reals) and m	mer er	ted		
W.													s) and menner es stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE		The state of the s							prese, 41				
BE	THE OF CERTIFIE	200					29c. LICE D38		MBER				(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CALL	E OF BEATH ATT	4 2T) (T -	Onler41		סכת	147			-170	7	4-95	
		O SOMPLETED CAUS	DE OF DEATH (ITEN	# 27) (/ype	, rrint)									

#600, Clinton, Maryland 20735



retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within Jours after death. Page 6 may be retained by the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at
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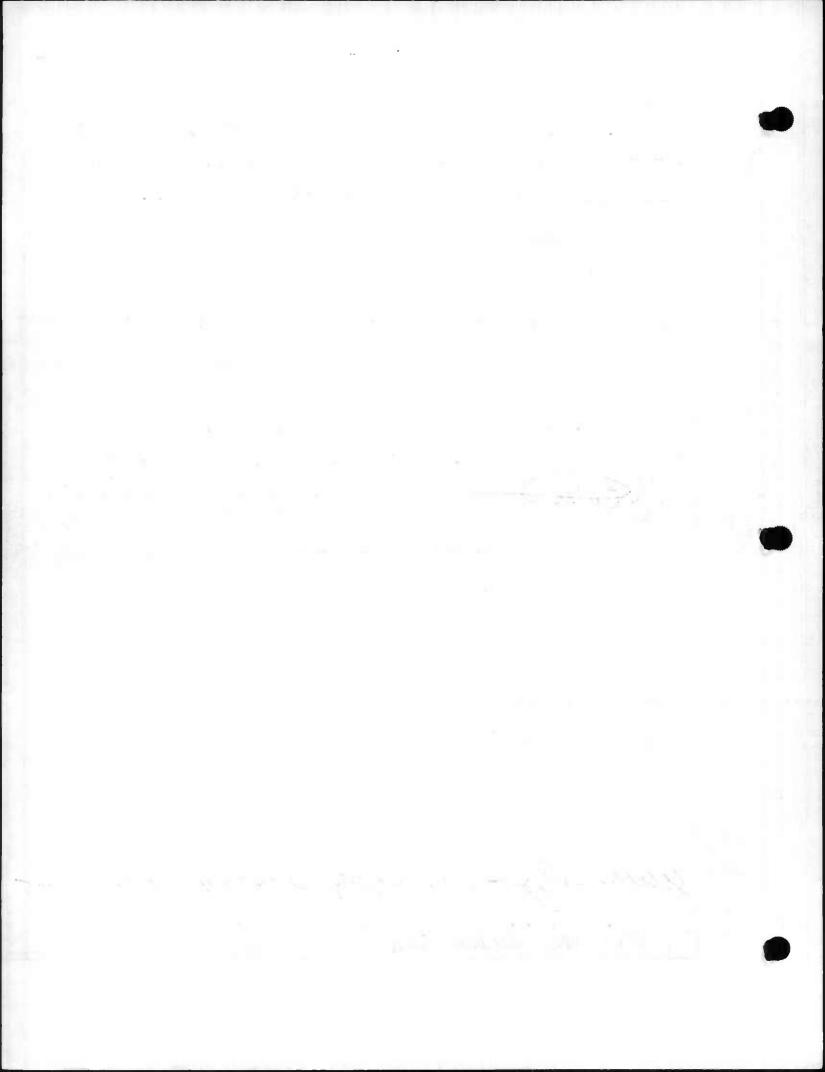
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH April 27,1995 John E. Smith 1216 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Aug 25, 1930 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 220-28-5068 64 MONTHS DAYS HOURS IX M 2 F VDC Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR North Arundel Hospital Glen Burnie A.A. RESIDENCE OF DECEDENT 10h. COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY Maryland Charles Waldorf 1 YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7930 Bensville Road 20603 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 VIND 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES XX NO Specify: FDRCES? 1 YES 2 ND IF YES, GIVE WAR DR DATES 1 Never Merried 2 Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Electrician United States Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surnan BE James Irving Smith Margaret Elizabeth Tayman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7930 Bensville Road, Waldorf, Maryland 20603 Jacqueline A Smith 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 20e. METHOD OF DISPOSITION

157 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) DATE ery, cremetory or other place) Joseph's Cemetery May 1 1995 Pomfret, Maryland 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Maryland 23. PART (Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ilns. Interval Between IMMEDIATE CAUSE (Final **Onset and Daeth** disease or condition Ventricular Fibrillation resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES ZYND 1 TES 2 ND BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: X YES 2 NO 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ng Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1X Natural 5 Pending 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On B is of axamination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Dev. Year) J, mD D 06054 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) M.D. 695 America Court, Davidsonville, Maryland 21035 William P. Jones. 31. DATE FILED MARY Day. 1640 32. RESISTRAR'S SIGNATURE
Julia d'Audion Randell



DIVISION OF VITAL RECORDS, P.O. BOX 68760

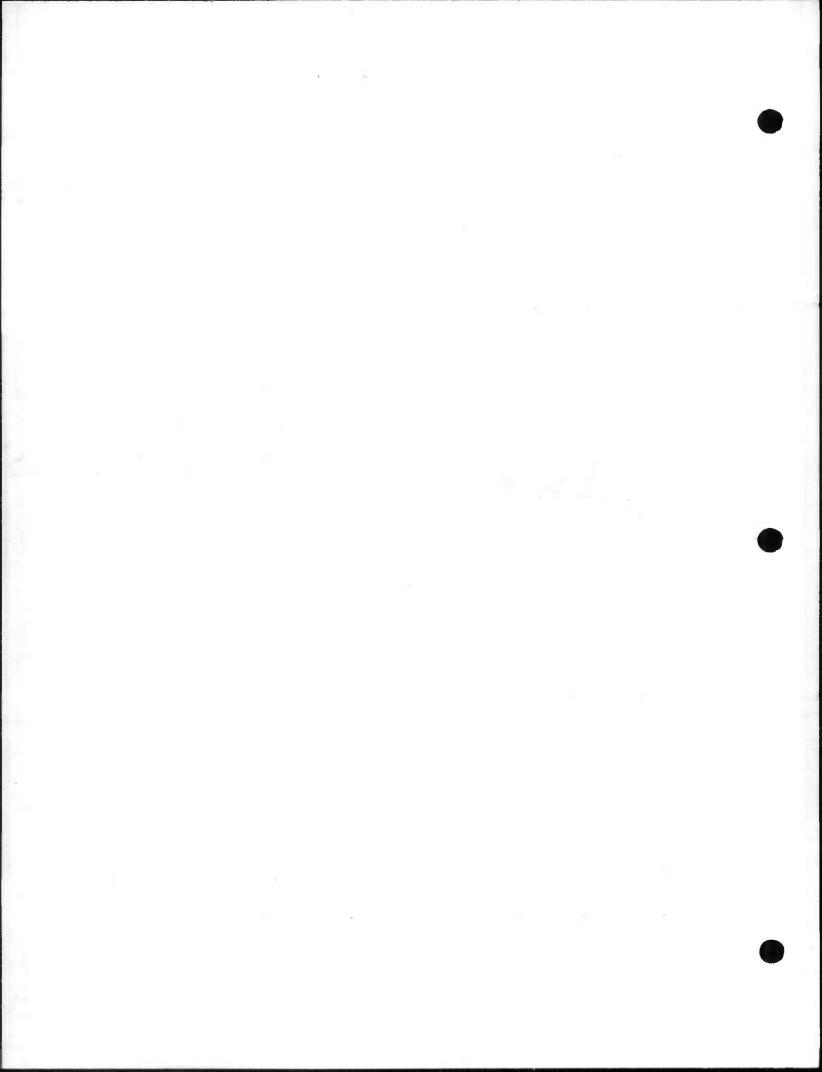
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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	ICATE OF	DEATH	RE	G. NO.			
1 3	1. DECEDENT'S NAME (First, Middle, La	st)				2. DATE OF OR	ATH	3	. TIME OF DEATH	
1 2	Donal	d Lee Sweener	V			Турга Т	April 27, 1995 FAR 6:00			
1 .	4. SOCIAL SECURITY NUMBER		XE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BII				
	214-32-9214	1 🕅 M 2 □ F		MONTHS DAYS	HOURS MIN.	(Month, Day,	Year)	Country)	ACE (State or Foreign	
			61 YRS.			, 1934	Maryl	.and		
	9a. FACILITY NAME (If not institution, gi			9b. CITY, TOWN	OR LOCATION OF	EATH	9c. CO	9c. COUNTY OF GEATH		
9	Greenbelt Nursi	ng Home		Greer	belt		Pri	Prince George's		
5	RESIDENCE OF DECEDENT 100. STATE 100. CITY TOWN OR CONTON									
DIRECTOR	100. CITY, TOWN ON EDUCATION									
	Maryland Prince George's Forestville									
A	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNT									
FUNERAL	1941 Tanow Pla	ce			20747		Imi	ted St	2+20	
Z	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMEO	13. WAS DE	CENDENT OF HISPA	NIC OBIGIN2 (See		Y	- American Indian,	
	1X Never Married 2 Merried	FORCES? 1 YE	S 2 NO	If yes, s	pecify Cuban, Mexic	an, Puerto Rican,	etc.)	Black, V	White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAN ON	DAIES	1 U YE	S XXNO Speci	ny:		Spec#y: Whi	to	
₽.	15. DECEDENT'S E	DUCATION	16a, DECEDENT'S	USUAL OCCUPAT	ION	16h KINO	OF BUSINESS/IN			
I E	(Specify only highest gr		(Give kind of life. Do NOT u	work done during n	ost of working	TOLK KUNO	OF BOSINESS/III	DOSINI		
17	Elementary/Secondary (0-12)	College (1-4 or 5+)	Disak			37/	7			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Disa	<u>neu</u>		N/2				
						AME (First, Middle,				
BE	George Washing	con sweeney				ebecca 1				
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					
	Donald Lee Sweer	ney	1941	Tanow	Place, F	orestvi	lle, Mar	vland	20747	
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ② Cremation 3 ☐ R	2	10b. PLACE AND DATE	OF DISPOSITION (A			20c. LOCATION -			
	4 Donation 5 Other (Specify)		emetery, cremetory or o	ther place)	nril 29	1995	Clintor	Mary	l and	
	21. SIGNATURE OF FUHERAL SETVICE	LICENSEE	CICILII.	22. NAME /	ND ADDRESS OF F	CILITY TOO	Funeral	Homo	land ,Inc 6633	
	DAR Z			013 7	l ovandor	Former	Largeral	LIME	, IIIC 0033	
\perp	1 Day								,Maryland	
	23. PART . Unter the diseases, or heart fellow	or complications that cause on a. List only one cause on	sed the death. Do	not enter tha m	ode of dying, au	ch aa cerdiac o	r reapiratory as	reat,	Approximata	
	IMMEDIATE CAUSE (Final	e. List only one cause on	eech line.						Onset and Death	
	disease or condition	_							Onset and Death	
	resulting in death)	a. DUE TO (OR AS	SCHEMIC S A CONSEQUENCE O	Cardiom	yopathy_					
				,						
CERTIFICATION	Sequentially list conditions,	b. OUF TO (OR AS	Orolary A	rtery D	rsease				-	
A	if any, leading to immediate cause. Enter UNDERLYING		7 4 44114244	,,						
[유	CAUSE (Disease or injury	C. OHE TO (OR AS	S A CONSEQUENCE O	5).						
Ē	thet initiated events resulting in deeth) LAST	002 10 (011 111	o w doubtoothot o							
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	PART II. Other algnificent condit	one contributing to deeth	but not resulting	in the underlying	a ceuse alven in	Part i. 24a. 1	MAS AN AUTOPSY	24h. W	ERE AUTOPSY FINDINGS	
EDICAL							PERFORMED?	AN	MILABLE PRIOR TO OMPLETION OF CAUSE	
<u></u>						10	YES X NO		F DEATH?	
Σ								1	☐ YES 2 ☐ NO	
PHYSICIAN:	DID TOBACCO USE CON	ITRIBUTE TO CAUSE	OF DEATH YE	S NO	UNCERTAI	N 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA)					
S	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/O	utpetient 3 🗆 DOA	OTHER:	ne 5 🗆 Residence	6 Other (Spec	(fv)			
_	27. MANNER OF OEATH	28a. DATE OF INJUR		E OF 28c, IN	JURY AT		HOW INJURY OC	CURED		
	Natural 5 Pending	(Month, Day, Year) IN.		DRK? YES 2 NO					
B B	2 Accident investigatio	28a PLACE OF IN ILL	RY — At home, ferm,			284 LOCATION	(Street and Numbe		- 41 - 41 - 41 - 41 - 41 - 41 - 41 - 41	
	4 Homicide B Could not I	" Dullding, atc. (S)	pecify)	arrest, tactory, orn		City or Town	, State)	or Hural Hout	e Number,	
COMPLETED	as assessed V									
립	29e. CERTIFIER (Check only	SICIAN: To the best of my known	owiedge, death occurr	ed at the time, dat	e end place, and due	to the cause(e)	nd menner ee ste	ited.		
8	one) 2 MEDICAL EXAM	NER: On the beels of examinat	tion and/or investigation	on, in my opinion,	death occured at the	time, data and pi	eca, end due to t	he ceuse(e) er	nd manner ea stated.	
S S	29b. SIGNATURE AND TITLE OF CERTIF	TIER			29c. LICENSE NU	MRER	204 DAT	E SIGNED /M	onth, Day, Year)	
00	Heory 1. Cox	Jan. gr)		0395			5-4-		
유	30. NAME AND ADDRESS OF PERSON			Print1	- 70	3 -		T	14	
	Dr. George C. Ha	Jar, Jr 4850	U Forbes	RTAG. #I	Lanham,	Maryla	nd 2070	6		
	31. DATE FILED MOREY. Day, Your 199	5 32. REGISTRARIS SIG	CHATURE RONALL							
	1 0 133	June will								



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Thomas Rodney Stuart 2. DATE OF DEATH MONTH 3. TIME OF DEATH HOMAS 154 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year HOURS DAYS 1 XM 2 1 212-38-7976 April 8 1927 68 Haiti 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Anne Arundel Annapolis 10a. STATE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Anne Arundel Annapolis 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 9 Chesapeake Landing 21403 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If was accelfy Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 VES X XO ВУ 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INOUSTRY (Spi Elementary/Secondary (0-12) College (1-4 or 5 +) Colonel/Officer **US Military** 6 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) James Austin Stuart Sara Raby Cross BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Herring Stuart 9 Chesapeake Landing Annapolis, Maryland 21403 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Lincoln Crematory 5/12/95 Brentwood, Maryland 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 147 Duke of Gloucester St. Annapolis, MD MUA 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only ne cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition_ emphysema resulting in death) Jagores DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1- Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 ___ MEDICAL_EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE mb MD24804 11-95 2

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Peterso

32, REGISTRAR'S SIGNATURE

i Develsor Rardoll

Robert

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31. DATE FILED (Month, Day, Year)

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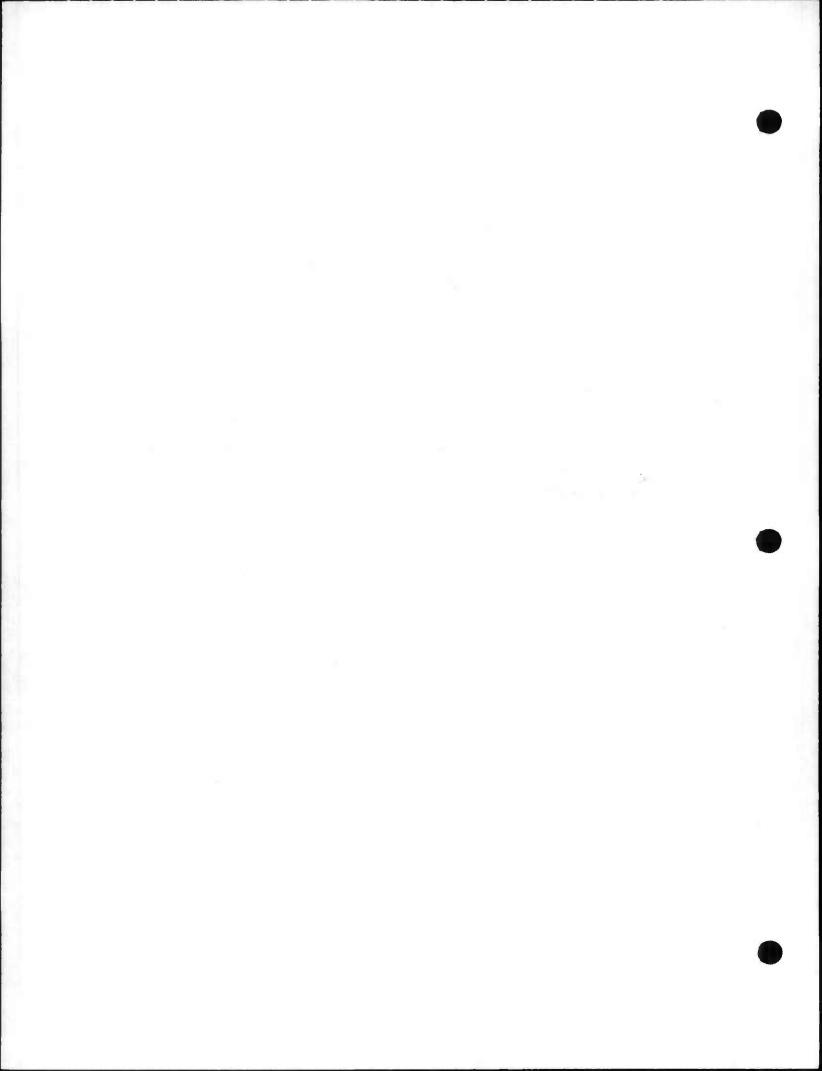
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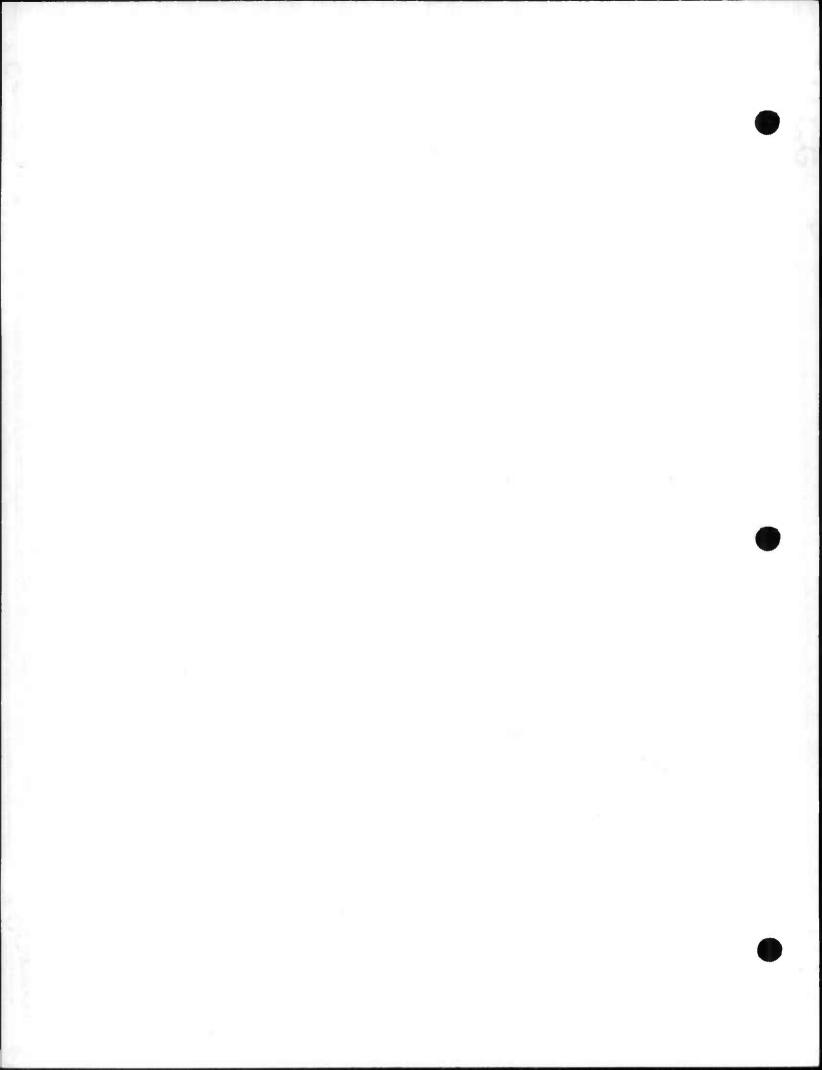
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ATTENDING PHYSICIAN: The law remittee that the death certificate he executed with
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Leat) 2. DATE OF DEATH 3. TIME OF DEATH April 24 1995 YEAR 8 P. Norman Stone 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Morth, Day, Year) NOV 26 1902 5. SEX 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 578-46-7873 1 🔀 M 2 🗌 F 92 DAVI Poland Se. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATN 9b. CITY, TOWN OR LOCATION OF DEATH Prince George DIRECTOR Prince Georges Hospital Center Cheverly RESIDENCE OF DECEDENT 10b. COUNTY IOC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Brandywine Maryland Prince George YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20613 12300 Crestwood Avenue South USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Il ves, specify Cuban, Maxican, Puerto Rican, etc.) 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi entary/Secondary (0-12) College (1-4 or 5+) Hardware Store 4+ Self-Employed 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Eli Staroshynski Freda Lubovitz BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Miriam Fanaroff 1390 Dolle Avenue Columbus Ohio must be 20s. METHOD OF DISPOSITION
1 G Burlal 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE King David Memorial Garden 4-26 Falls Church VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST HAUI 6 Injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s WAS AN AUTOPSY shows any 1 | YES 2 ()QIO OF DEATH? HR 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Box \) NO \(\Box \) UNCERTAIN \(\Box \) 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem OTHER 1 WES 2 NO satient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH DATE OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED marked, 1 | Vatural
2 | Accident 1 TES 2 NO BY Investigation 26a. PLACE Of INJURY — At home, farm, street factory, office building, etc. (Specify) City or Town, States 49 3 Suicide or Rural Route Number COMPLETED 6 Could not be item 28 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT; If II 2 MEDICAL EXAMINER: On the atigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENT BE 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

37 BEGISTRAR'S SIGNATURE



	1. DECEDENT'S NAME (First, Middle, Last)			CENTIF	ICATE O	HEALTH AND	_	REG. NO).		
	WEI-HUI	C					MONTH	DEATH	MY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	SHEN IF UNDER 1 YEAR	F UNDER 24 HRS.	APRI 7. DATE O		,199		9:10 P
	212-02-2444	1 🗆 M 2 🔯 F	E	72 YRS.	MONTHS DAYS		(Month,	Day, Year)	1923	Country)
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOW	N OR LOCATION OF		12,	T	INTY OF DE	
OR	THE JOHNS HOPKIN	S HOSPITA	AL_		BALTIM	ORE CITY			1	N/A	
DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ry		10c. CIT	Y, TOWN OR LOC	CATION					10d. INSIDE CITY
	Maryland Montg	omery		Ro	ckville						LIMITS?
MAL	10e. STREET AND NUMBER					101. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
N L	199 Rollins Aven					20852			USA	Perm	. Residen
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES	2 NO	II yes,	ECENDENT OF HISP specify Cuban, Mexi- ES 2 X NO Spec	cen, Puerto R	(Specify Yellcan, etc.)	e or No—	Black,	- American Indian, White, etc.
	15. DECEDENT'S EDU (Specify only highest grad	JCATION completed)		16a. DECEDENT'S	USUAL OCCUPA	TION	16b.	KIND OF BU	SINESS/IN	*	
LETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	-)		work done during se retired.)	inves or working					
COMP	12 17. FATHER'S NAME (First, Middle, Last)	2		Te	eacher			lucat			
S	Huang Chen					18. MOTHER'S N		iddie, Maiden	Sumeme)		
20	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Stree	Kweitz		er CIIV or Tow	vn Stata 7k	n Code)	
2	Chu Shen					Avenue, I					20852
	20a, METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Ren	noval from State	20b.	PLACE AND DATE	OF DISPOSITION	Name of	DATE	-		City or Tow	
	4 Donation 8 Other (Specify)		Ga	etery, crematory or o	eaven C	emetery	5/6	Sil	ver S	Sprin	g, Marylan
	21. SIGNATURE OF PUNERAL SERVICE LY	in the	-		111800	New Hanger Spring	moshir	nes-k e Ave	inalo nue	11 Fu	neral Home
	23. PART I. Enter the diseases, or shock, or heert fellure. IMMEDIATE CAUSE (Finel	complications that List only one cau	t caused se on ea	the death. Do and the line.	not enter the n	node of dying, su	ch aa cerdi	ec or reep	iratory ar	rest,	Approximate Interval Between Onset and Dea
	disease or condition resulting in death)			CONSEQUENCE OF	FI.						2 way
CN	Sequentially list conditions, If any, leading to immediate	a 61:061	art		rup. fo	car					Smunt
IFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	C. DUE TO	(OR AS A	CONSEQUENCE OF	F):						
2	resulting in death) LAST	d									-
MEDICAL	PART II. Other algnificent condition	ne contributing to	death bu	ut not recuiting	In the underly	ing cause given i	n Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDING
3							- 1	1 TES 2	NO □		COMPLETION OF CAUSE OF DEATH?
Σ.	DID TOBACCO USE CONT	RIBUTE TO CAI	USE O	F DEATH YE	S D NO	□ UNCERTA	IN []				YES 2 THO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			8. PLACE OF DEAT							
2	1 YES 2 NO	HOSPITAL:	ER/Outpo	Itlent 3 DOA	OTHER: 4 Nursing Ho	ome 5 🗌 Realdence	6 Other	(Specify)			
H	27. MANNER OF DEATH 1 Netural 5 Pending	28a, DATE OF (Month, Da		28b. TIM		NJURY AT YORK?	28d. DE\$0	RIBE HOW I	NJURY OC	CURED	
6	2 Accident Investigation	20. 01.405.01	E 104 11 1500			YES 2 NO					
3	3 Suicide 8 Could not be 4 Homicide determined	building,	etc. (Speci	— At home, tarm, s	Rreet, tectory, of	lice	281. LOCA	TION (Street of Town, State)	end Number	r or Rural Ro	ute Number,
COMPLEIED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS 2 MEDICAL EXAMINI	ICIAN: To the best of a									
				and or investigation	n, in my opinion,	29c. LICENSE NU		no piace, an			
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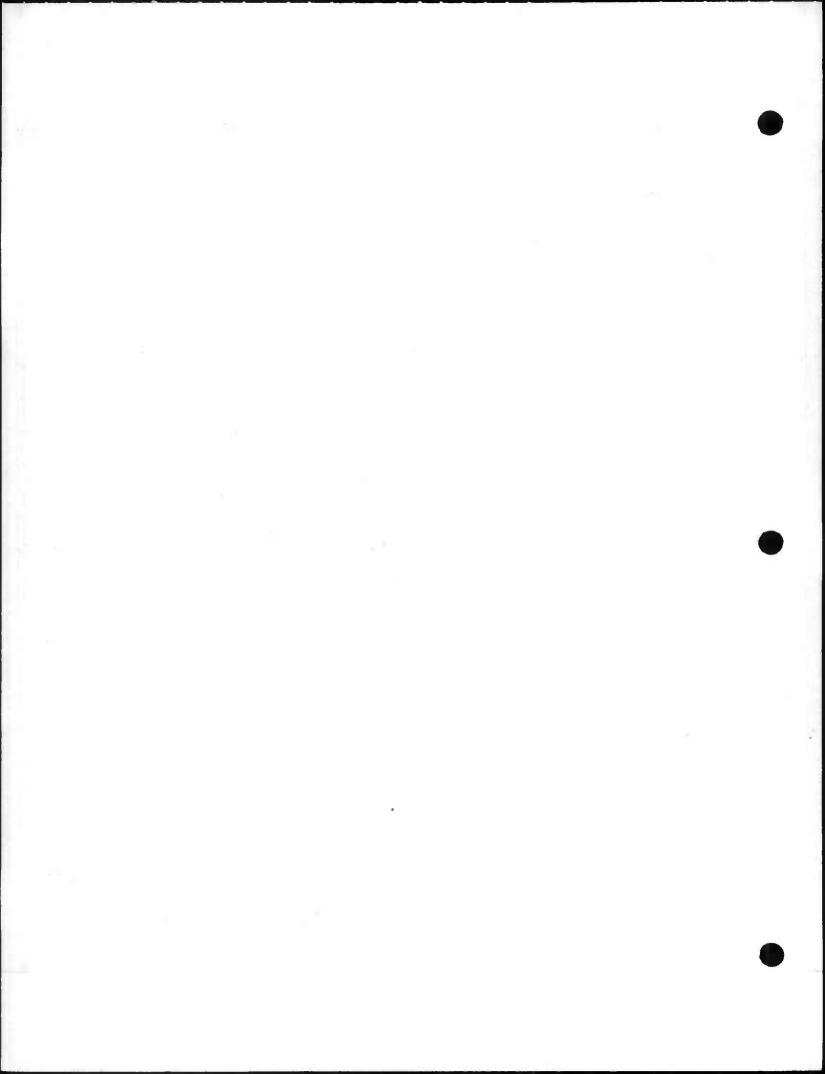
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examin
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Schana Jenning (75 W. April 29 11 45 6. AGE (In yrs. lest birthday) 5 SEY 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Oct. 21,1913 1 🖾 M 2 🗌 F 81 577-07-8637 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4865 66th Avenue Hyattsville Prince Georges RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Hyattsville 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4865 66th Avenue 20784 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 X Married 1 YES 2 NO Specify: White Specify: В 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify College (1-4 or 5+) Police Officer D.C. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) te Charles Schana Anna Josepha Duchon BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Girlie Schana 4865 66th Avenue, Hyattsville, MD must be 20a. METHOD OF DISPOSITION
1 Burlel 2 Gremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Metropolitan Crematory 4/29/95 Alexandria, VA 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil.Spr.MD 20901 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each ilna. Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition chronic liver failure several month resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic Laennecs Cirthosis CERTIFICATION Sequentielly list conditions. If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST injury. PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any 1 YES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 0 4 Nursing Home 5 Residence 6 Other (Specify) 27, MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 00 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Tem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner se stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) BE 022780 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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DIVISION OF VITAL BECORDS DO BOX 68750

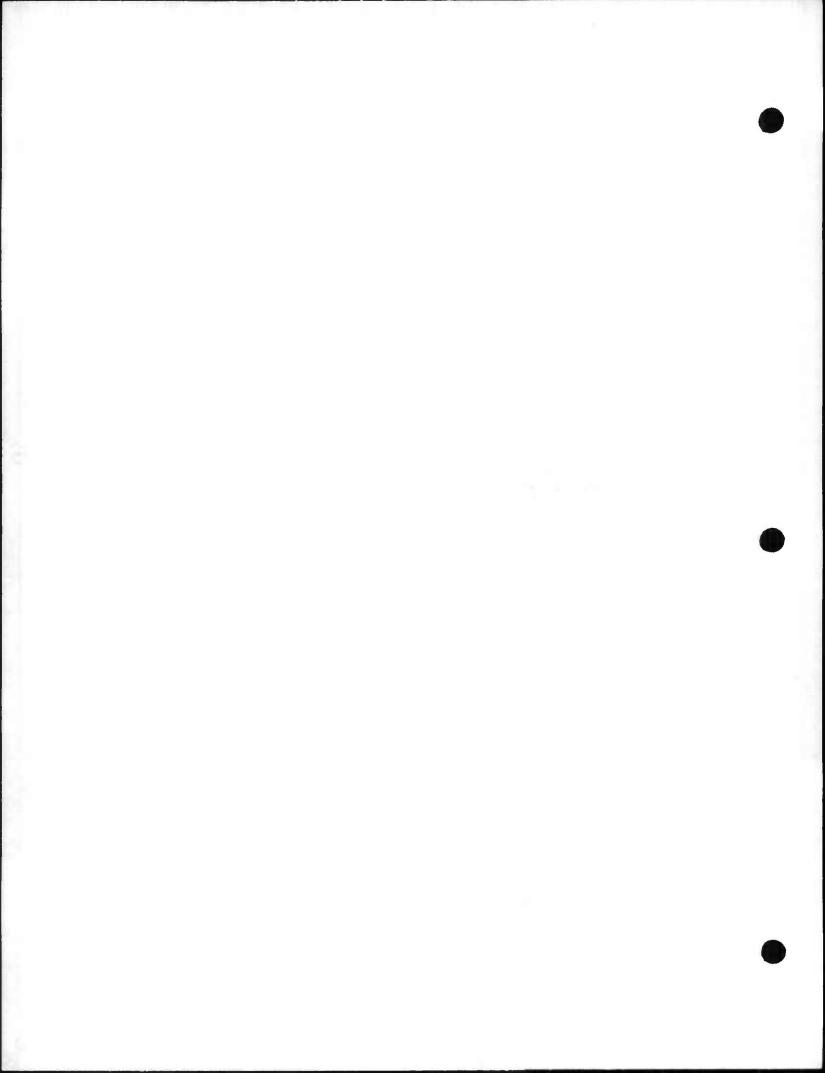
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	OR ATTENDING PHYSICIAN:
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYI	LAND / DEPARTM CERTIFIC				GIENE		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		3. TIME OF DEATH
	Maxine Morrison	Stahler				April	29.	1995	1:15 AM
	TOTAL SECTION AND ADDRESS OF THE PARTY OF TH			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BII (Month, Day,	RTH Weet		IPLACE (State or Foreign
	214-00-1730	□ M 2 X F 3 8	YRS.			Dec.		56	Maryland
œ	9e. FACILITY NAME (If not institution, give street		90		OR LOCATION OF DE	ATH	9c.	COUNTY OF	EATH
DIRECTOR	Suburban Hospi	tal		Bethe	sda		1	Montgo	omery
REC	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION				10d. INSIDE CITY
	Md. Mont	gomery	Si	lver	Spring				LIMITS? 1 XYES 2 NO
FUNERAL	10e. STREET AND NUMBER				. ZIP CODE		100	. CITIZEN OF	WHAT COUNTRY?
NE NE	2613 Beechmont				20906			USA	
F	11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1 YES	2 W O	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Spe	cify Yes or N	lo- 14. RACI Black	American Indian, k, White, etc.
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR E	DATES	1 TYES	2 NO Specify	<i>r</i> :	•	Spec	White
ED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ON	16a. OECEDENT'S USI	UAL OCCUPATIO	ON	16b. KIND	OF BUSINES	SS/INOUSTRY	
ᄪ		college (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo tired.)	st of working				
COMPLETED		4+	Homem	laker		H	omema	aker	
00	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Maiden Suma	ame)	
BE	Leon Morrison					ah Ros			
5	19e. INFORMANT'S NAME (Type/Print)		1		nd Number or Rural F				
	Stuart Stahler	1 40	2613 b. Place and date of d						1g,Md. 209
	20e. METHOD OF DISPOSITION 1.XS Burlal 2 Cremetton 3 Removal 4 Donation 5 Other (Specify)		metery, crematory or other	place)				ON — City or To	
	21. SIGNATURE OF FUNERAL SERVICE LIGENS		Judean Ga		May D ADDRESS OF FAC	7 1,95		Olney,	Md.
	Elina			Edwa	rd Sage	el Fun	eral	Direc	ction
-4	23. PART i. Enter the diseases, or com	nilcations that cause	d the death Do not	1091	Rockvi	11e P	ike H	Rockvi	11eMd.2085
	Shock, or heart fellure. List	only one cause on	each line.	enter the mo	ua or dying, auci	n aa cardiec o	r reapirator	ry arreat,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	110	INABANA						Onset and Death
	resulting in death) a	DUE TO (OR AS	A CONSEQUENCE OF):						3 YRS
z			,						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE OF):						
2	CAUSE (Disease or injury								
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):						
S	d								
AL	PART ii. Other aignificant conditions co	ontributing to death b	out not resulting in ti	he underlying	ceuse given in	Part i. 24a. \	MAS AN AUTO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
90							YES 2 PN	/	COMPLETION OF CAUSE OF DEATH?
ME					/	_ 1			1 TES 2X NO
N	DID TOBACCO USE CONTRIB	UTE TO CAUSE C			UNCERTAIN	1 🗆			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	28. PLACE OF DEATH (C	Check only one)					
₹	1 VES 2 NO 1 0	Inpetient 2 ER/Outs	patient 3 DOA 4	Nursing Home	5 Residence		**		
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF	WOI	PRY AT PRK?	28d. DESCRIBE	HOW INJURY	Y OCCURED	
ВУ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	/ — At home, farm, stree			281. LOCATION	(Street and Mi	umber or Rumi D	Inseln Alsembras
TED	4 Homicide B Could not be	building, etc. (Spec	cify)	i rootory; orneo		City or Town	, State)	union or norm n	oute Number,
COMPLET	298. CERTIFIER 1 CERTIFYING PHYSICIAN	To the best of my know	lados doub assumed a	Oh offer dear		Eggi Compa			
ž I	(Check only one) 2 MEDICAL EXAMINER: O								and manner or stated
	29b. SIGNATURE AND TITLE OF CERTIFIER	710							
BE	2	Whit).			29c. LICENSE NUM	407	29d.	4 21	(Monti, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	MICETED CAUSE OF DE	EATH (ITEM 27) (Type, Prin	e)	ما ما مرد	101		7/6	1/73
	Joseph HAGGERT	/ -	MODICAL CX		DRIVE K	LOCK VIII	10 L	W 21	850
	31. DATE FILED (Month, Day, Year)	A REGISTRAR'S SIGN	ATIORE			2-27/0	- /-		
- 1	MAY 02 1995	faces a manager.	narball						



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the feature of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competenty filled in by the funeral directs, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hypere prior to burial, computed in medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIE		
1. DECEDENT'S NAME (First, Middle, Last)	Robert	Sw			2. DATE OF DEATH	9 1992	ZEAR 3. TIME OF DEATH
577 54 1274	1 📉 M 2 🗆 F	95 YRS. M	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			BIRTHPLACE (State of Foreign Country) axahachie,TX.
90. FACILITY NAME (If not institution, give street Comfort Zone Care RESIDENCE OF DECEDENT	· ·	9	Seabre	R LOCATION OF D	EATH		ce George's
10e. STATE 10b. COUNTY			ningtor				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
1212 Quincy St., N				20011		Uni	n of what country? ted States
1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES : IF YES, GIVE WAR OR DATE WW 1.	2 NO	If yes, spe	ENDENT OF HISPAI colfy Cuben, Mexico 2 X NO Specif	NIC ORIGIN? (Specify Y nn, Puerto Rican, atc.)	ee or No— 14	Black Specify: Black
	mpleted) College (1-4 or 5+)	life. Do NOT use n	k done during mo: etired.)	N it of working	16b, KIND OF B		
12 17. FATHER'S NAME (First, Middle, Last) J. H. Swanc	5+	Attorn	ey	18. MOTHER'S NA	Priva ME (First, Middle, Maide Willie W.		
190. INFORMANT'S NAME (Type/Print) James Williams	: <u>y</u>				Route Number, City or To	wn, State, Zip Co	ode)
20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remova	20e. METHOD OF DISPOSITION 15 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremating or other place) Complete Cremating or other place)						
23. PART. Enter the diseases, or cos shook, or heart/failure. Lis	mplications that caused th	e death. Do not	7400 0	eorgia .	eraL Servi Ave., N.W., has cardiac or rea	Wash.,	D.C. 20012 t. Approximate
IMMEDIATE CAUSE (Final disease or condition resulting in death)	pertenaue a	0.0000	dustre	anda	vasiala	deres	Interval Between Onset and Beath
Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO						
PART II. Other significant conditions of	contributing to death but	not resulting in t	the underlying	cause given in	Part I. 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS
						RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	26.	PLACE OF DEATH (NO Check only one)	UNCERTAIN	N 🗆		
1 PYES 2 NO 1 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	PF 28c. INJL Y WOI	IRY AT	8 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCUP	RED
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stre	et, tectory, office		26t. LOCATION (Street City or Town, State	end Number or	Rural Route Number,
	N: To the best of my knowledg						euse(e) and menner ee stated.
296. SIGNATURE AND TITLE OF CERTIFIER REPORT OF MANAGEMENT APPRESS OF SERVICE OF SERVIC	diffugm	1	d	Pac. LICENSE NUN	BER	2011. DATE S	IGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERBONNING C	COMPLETED CAUSE OF DEATH	MD. 50	109 R	upurn	Cf Cf	Ser.	Mo20748
MAY 02 1995	32. REGISTRAR'S SIGNATU			•	-	0	

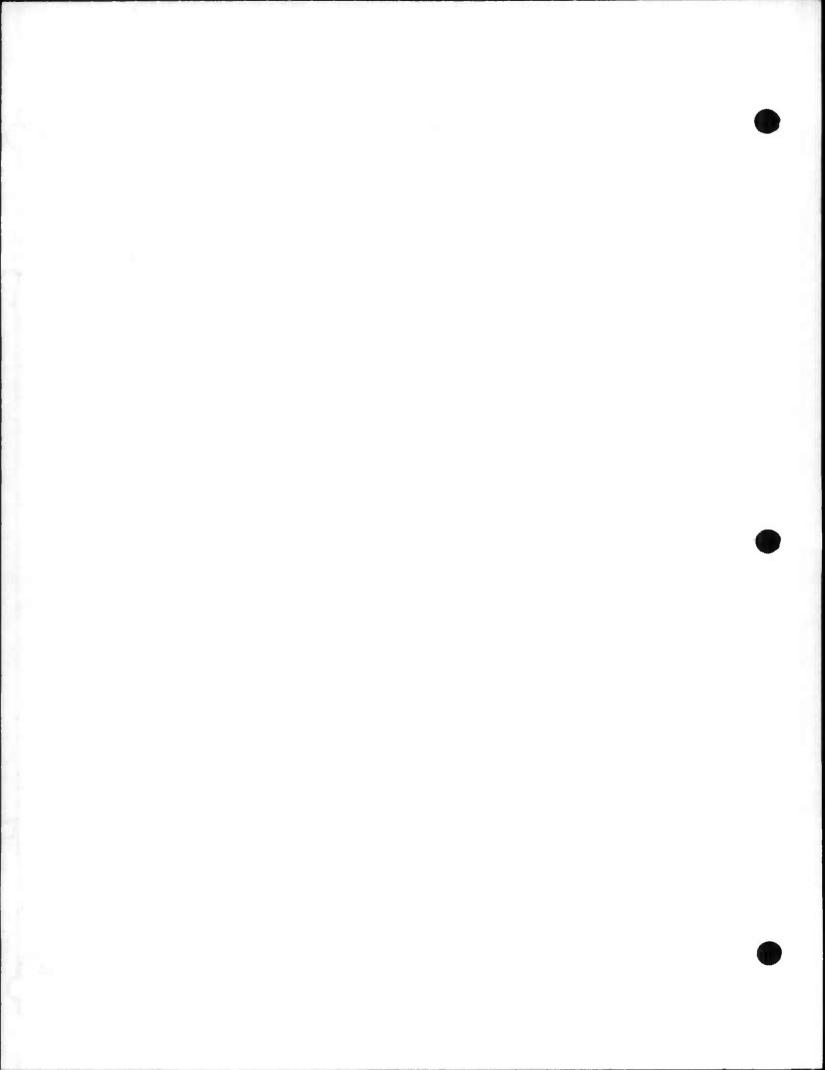
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	ITMENT OF H	EALTH AND	MENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATN			TIME OF DEATH	
		3.	SMITH			APRIL 27.	1995	YEAR 1.	.00P	м
	4. SOCIAL SECURITY NUMBER		(in yrs. last birthday)	F UNDER 1 YEAR	F UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			ACE (State or Foreign	
	212-12-6846		3 YRS.	MONTHS DATS	HOURS MIN.	May 21,	1911	"	yland	
00	9a. FACILITY NAME (If not institution, give st				R LOCATION OF D	EATN	9c, COUNT	Y OF DEAT	TH .	
15	Prince Georges	Hospital		Chev	erly		Pri	nce	Georges	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10	d. INSIDE CITY	
	Maryland Pri	nce George	s (Glenard	en			1	LIMITS?	
\\\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZ	EN OF WHA	T COUNTRY?	
FUNERAL	7919 Cawker Av				2070			S.A.		
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 X YES	2 NO	If yes, spe	city Cuban, Mexico	NIC ORIGIN? (Specify Year, Puerto Ricen, atc.)	s or No 1	4. RACE — Block, W	American Indian, fhite, atc.	
B	3 Widowed 4 Divorced	1945-19	48	1 TYES	2 NO Specif	fy:		Specify:	Black	
E G	15. DECEDENT'S EDUC (Specify only highest grade of	CATION	16a. DECEDENT'S	USUAL OCCUPATION	IN .	16b. KIND OF BU	JSINESS/INDU	STRY		\dashv
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	IIIe. Do NOT us	· ·						
M M	7th		Anima	l Caret			rernme	ent		
	17. FATHER'S NAME (First, Middle, Last)	Ъ				AME (First, Middle, Maide				
H	George E. Smit	П	405 444 1140	ADDDDDD (0)		E. Brewer				_
2	Mary K. Smith	(Wife)				Route Number, City or Ton Glenarde			706	
	20e. METHOD OF DISPOSITION	20h		OF DISPOSITION /Ne			OCATION - CI			-
	1 № Burial 2 □ Cremation 3 □ Remo			Mem.			aurel			
	21. SIGNATURE OF FUNERAL SERVICE LICE		0	22. NAME AN	D ADDRESS OF FA	CILITY				-
	- Oanex	HXXX	Weber	SNOW	DEN FUI VILLE,	NERAL HON		.A.		
	23. PART I. Enter the diseases, or co	omplications that caused	I the death. Do r	ot enter the mod	de of dying, suc	MD 2085 th as cardiac or resp	olratory arre	nt,	Approximata	\dashv
	ahock, or heart fallure. L	List only one cause on a	nch Ilna.	VA F	-011	0.5			Interval Between	
	disease or condition	KESPIK	HIOK	·Y	-AIN	URE			ONF-DI	AY
		DUE TO (OR AS A	CONSEQUENCE OF	F):	musi	VIII O O TULL			0 1	7
No.	Sequentially list conditions,	METAB	ONIC	ENC	CAHAY	101/H 11TY			>2- Cay	
ΑŢ	if any, leading to immediate cause. Enter UNDERLYING	END ST	A-GF	- MET	ACTA	TIC C	4001	Model	>2-400	16
FI	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF	7:		COING	ELY CIV	VUP UP		J
CERTIFICATION	resulting in death) LAST	PROSTA	+TIC	CAB	RCIEN	OMA	- /	>	> 2-yea	4
1	PART II. Other significant conditions	contributing to death b	ut not resulting	n the undariving	Cause given in	Port I 240 MAS AL	ALIMOREY	7.45 9/6	RE AUTOPSY FINDINGS	
ICAL	Detrydra	tipu: A	TYRA M	agr		PERFO	RMED?	AM	AILABLE PRIOR TO MPLETION OF CAUSE	5
MEDIC	DIABETESM	ELLITTIS >	HTN	He 6,705	-NNR	1 🗆 YES	ZIVNO		DEATH?	-1
	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S NO N	UNCERTAI	N X	1	1	NES AL NO	-1
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT		OTTGER(IA)	750		1 ,	(7)	\exists
Sic	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	atlent 3 DOA	OTHER: 4 Nursing Home	5 - Residence	8 Other (Specify)				\neg
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JRY AT	28d. DESCRIBE HOW	INJURY OCCU	RED		đ
à	1 Natural 5 Pending 2 Accident Investigation		7	M Y Y	ES 2 NO		-			
<u>a</u>	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm,	prest, factory, office		281. LOCATION (Street City of Town, State	and Number or	Rural Route	Number,	
	29a. CERTIFIER									4
COMPLET	(Check only	SIAN: To the best of my knowl 3: On the basis of examination								J
	29b. SIGNATURE AND TITLE OF CERTIFIER	120 00	T T T T T T T T T T T T T T T T T T T	n, in my opinion, de						
) BE	THE OF GENERAL	Savos	In)	D-34	525	≥ 0 €	1-2	8 9 (
입	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATN (ITEM 2) (Type,	Mino XIO A	sad A	220.AA	0 2	0,10	0- 20711	
	31. DATE FILED (Month, Day, Year)	12 BEGISTRADIO CIONI	MILLER	ILVIUE D	The man	The state of the s	V-K	, - 01	(-00111	V
	MAY 02 1995	32 REGISTRAR'S SIGN	Rodall							
النب	11/H1 VA 1333	Many or marger	- and Adversal							- 1



Pages 1, 2, 3

permit.

DALLIMORE, MARTLAND ZIZIS-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-trans	on, or removal.	he medical examiner must be notified at once.
STATE OF STA	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit	be nied within 72 hours after death with the State Dept. of Health and Merital Hyglene phor to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HECTOR ASUNCION 31. DATE FILED (Month, Day, Year)

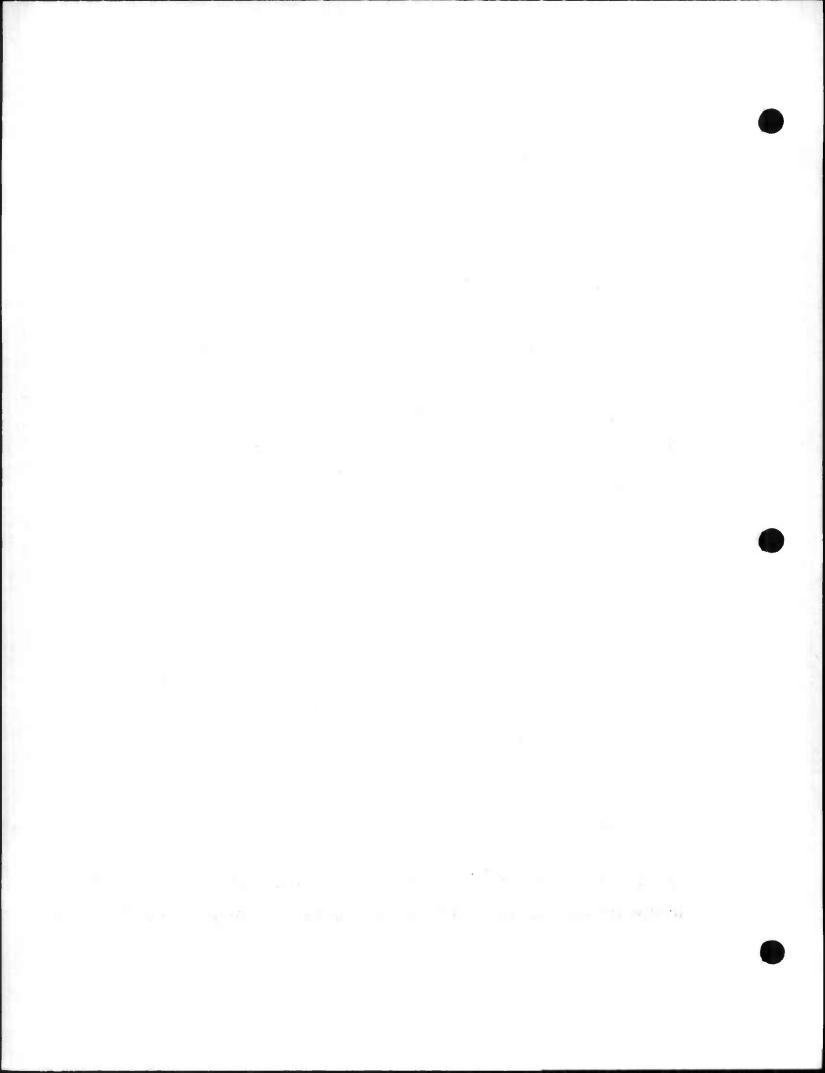
A. REGISTBAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF CEATH 28, 1995 WESLEY **STOKES** SR APRIL 12:15 PM LEE 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday IF UNDER 1 YEAR 7 DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DEC. 3,1938 215-36-3389 56 HOURS 1 M 2 - F VIRGINIA YRS. 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN DR LOCATION OF GEATH 9c. COUNTY OF OEATH DIRECTOR SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY. TOWN DR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY ROCKVILLE YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN DF WHAT COUNTRY? 1307 CRAWFORD DRIVE 20851 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1. YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Guban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried 1959 GIVE WARYOR OATES BY Specify: WHITE 3 Wildowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

work rhone during most of working COMPLETED 15. DECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only high (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) SUPERINTENDENT CONSTRUCTION once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Mickelle Maiden Surname HERBERT F. 70 STOKES CORA LEE LOWERY BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 NANCY L. STOKES 1307 CRAWFORD DRIVE ROCKVILLE, MARYLAND pe 20a METHOD OF DISPOSITION
1,1 Surial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must ! DATE PARKCAWN "C'EMETERY 5/2/95 4 Donation 6 Other (Specify) ROCKVILLE, MARYLAND examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
MURIEL H. BARBER FUNERAL HOME P.O.BOX 5038 LAYTONSVILLE, MARYLAND medical 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disesse or condition resulting in death) HEMMORRHAGIC CEREBRAL INFARCTION 6 Days event, 1 DUE TO (OR AS A CONSEDUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEDUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury item 23 shows any injury, or other OUE TO (OR AS A CONSEDUENCE OF): thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? DIABETES, PREVIOUS MYOCARDIAL INFARCTIONS. 1 YES 2 NO HYPERTENSION 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLFTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 THO 1 Pinpatient 2 ER/Outpatient 3 DOA marked, or 27. MANNER DF DEATH 28a. DATE DF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending M 1 YES 2 ND BY Investigation 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) after de 28 is ED 8 Could not be 4 Homicide determined COMPLET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER P. Nicholag Kobilannyn 8 29d, DATE SIGNED (Month, Day, Year) ►APRIL 29, 1995 2

Gammy rown RUND, Gennymown, up

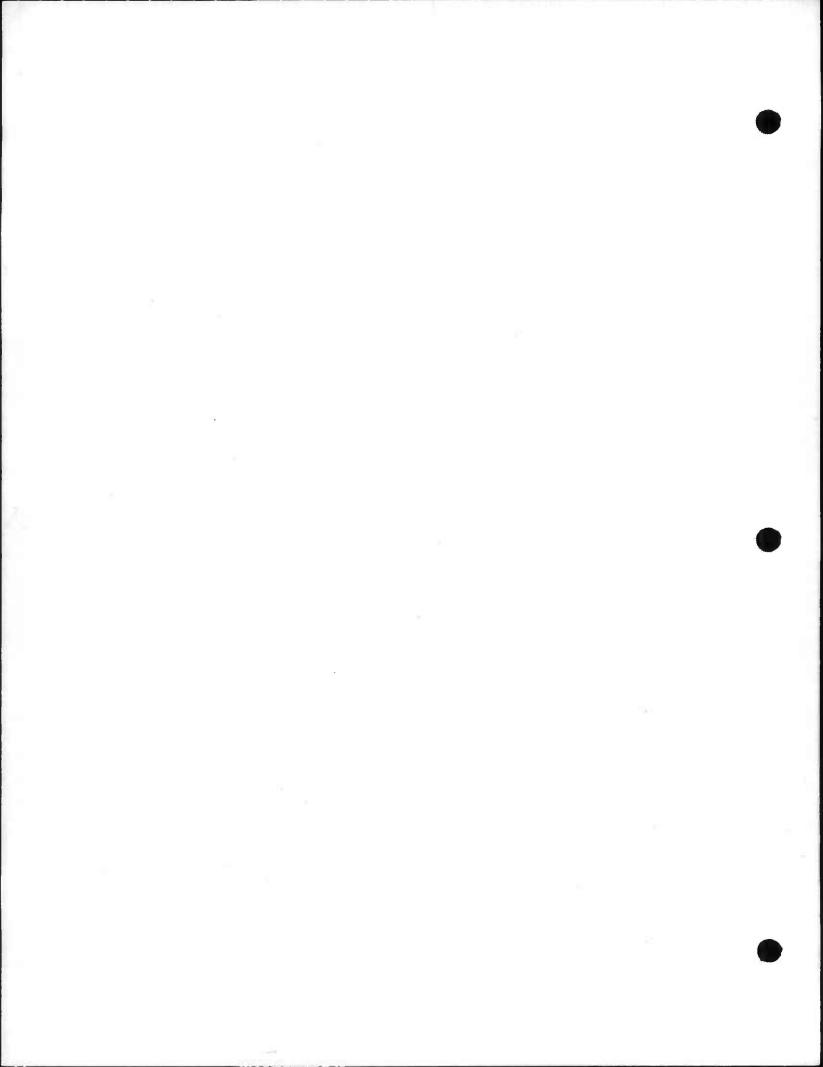


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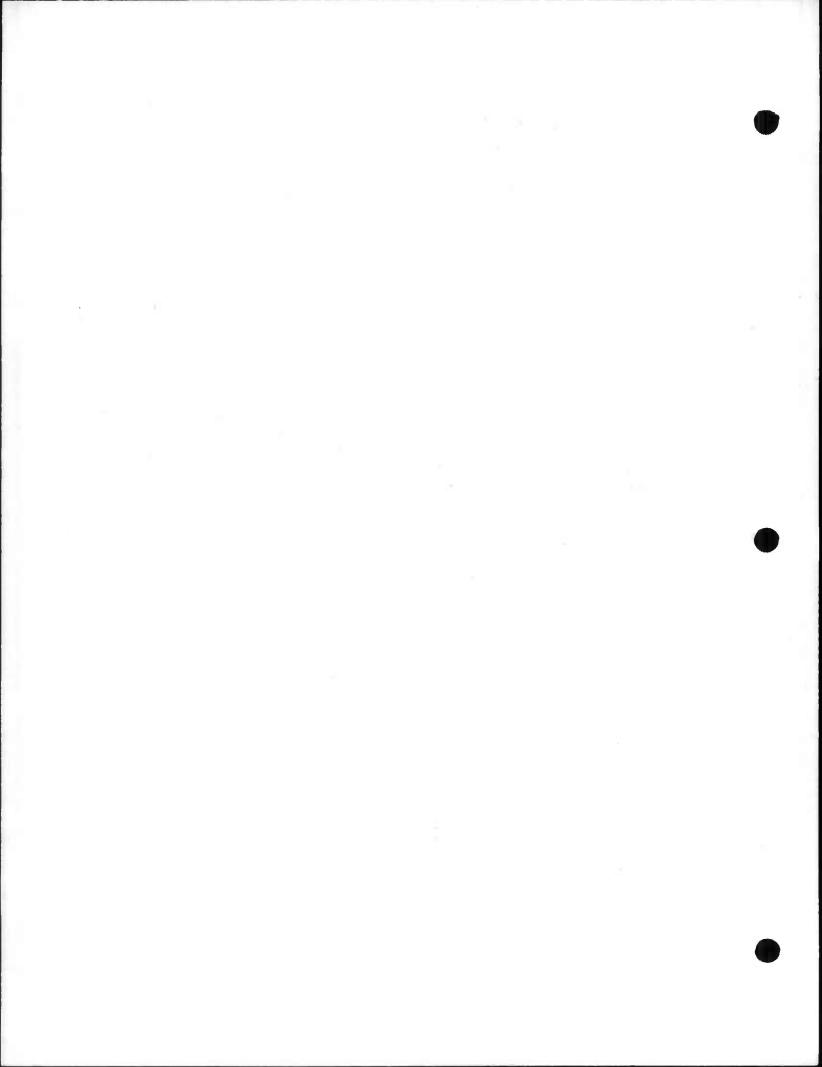
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SICIAN	VAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	History of is marked no than 22 shains not injure to other and the analysis and an extension of the continued of the continue
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest)			2. DATE OF DEATH	MY YEAR	3. TIME OF DEATH	
		Sarsfield		05 02	1995	8:45 P M	
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (in yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 H		6. BIRTI Count	HPLACE (State or Foreign	
	579-66-8500 1 M 2 🗆 X	89 YRS.		March 25,1		eland	
~	9e. FACILITY NAME (If not institution, give street end number)		9b. CITY, TOWN OR LOCATION O	F DEATH	9c. COUNTY OF D		
DIRECTOR	Villa Rosa Home		Mitchelville		Prince	Georges	
E E	10e. STATE 10b. COUNTY		TY, TOWN OR LOCATION			10d. INSIDE CITY	
	none none	Wa	shington, D.C.			1 XYES 2 NO	
RA	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF		
FUNERAL	3814 Benton Street, N.W.	ENT EVER IN U.S. ARMED	20007	SPANIC ORIGIN? (Specify Yes	U.S.A		
	1 Never Married 2 Merried FORCES?	1 YES 2 HO WAR OR DATES	It yes, specify Cuben, M	xican, Puerto Rican, atc.)	Bine Spec	E American Indien, k, White, etc.	
ВУ	3 🔀 Widowed 4 🗌 Divorced			oony.		ite	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of	S USUAL OCCUPATION work done during most of working	16b. KIND OF BU	SINESS/INDUSTRY		
길	Elementary/Secondary (0-12) College (1-4 or		sewife		L		
N O	17. FATHER'S NAME (First, Middle, Last)	nous		OWII NAME (First, Middle, Meiden	home		
E C	John Audley			dget Riley	Surname)		
m m	19e. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street and Number or R		vn, State, Zip Code)		
2	James B. Sarsfield	9700 (arriage Rd., K	ensington, M	id. 20895		
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Removal from State	20b. PLACE AND DATE	OF DISPOSITION (Name of	OATE 20c 10	CATION - City or To	own, State	
	4 Donation 5 Other (Specify)	Gate of h	eaven Cemetery		lver Spr	ing, Md.	
	21. SIGNATURE TO SERVICE LICENSIE	110	DeVol Funer				
	Amr. Dil	101	2222 Wiscon	sin Ave. N.W	.,Wash.,	DC 20007	
	23. PART. Enter the diseases, or complications shock, or heart fallure. List only one.	hat caused the deeth. Do euse on each lina.	not enter the mode of dying,	auch as cardiac or reap	Iratory arrest,	Approximata interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	110-				Onset and Dasth	
	reaulting in death) a.	TO (DR AS A CONSEQUENCE O	ME)			(Xex)	
-	- 15	elu-Khi	er.			Din.	
5	Sequentially list conditions, if any, leading to immediate	TO (OR AS A CONSEQUENCE O	PF):			173	
CA	CAUSE, Enter UNDERLYING CAUSE (Disease or Injury	1841					
E	that initiated events reaulting in death) LAST	TO (OR AS A CONSEQUENCE (PF):				
CERTIFICATION	d						
-	PART II. Other aignificent conditione contributing		in the underlying ceuze given	In Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS	
MEDIC	Decolor vicers,	Durkotes	Type II	1 D YES	A	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
Z H					(1 TYES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO C			AIN 🗆			
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		TH (Check only one) OTHER:				
HYS	1 YES NO 1 Inpatient :	DF INJURY 28b, TII	#E OF 28c, INJURY AT	26d. DESCRIBE HOW I	N ILIEV OCCUPED		
	1 Netural 5 Pending (Month		JURY WORK? M 1 YES 2 NO	200. DESCRIBE HOW I	MJORY OCCURED		
р ву	3 Suicide 28e. PLACI	OF INJURY — At home, term, g, atc. (Specify)		281. LOCATION (Street	end Number or Rural F	Route Number,	
COMPLETED	4 Homicide determined	g, atc. (Specify)		City or Town, State)			
PLE	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best	of my knowledge, death occur	red at the time, date end place, end	due to the cause(s) end mar	nner as stated.		
S O			on, in my opinion, death occured at			e) and manner as stated.	
BE C	290. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE	NUMBER	29d. DATE SIGNED	(Month, Day, Year)	
TO B	1 xuns	- puo	10%	1261	15-2	55	
-	30 NAME AND ADDRESS DE PERSON WHO COMPLETED C	USE OF DEATH (ITEM 27) (TYP)	DIL A . AC.	0 /	10 1	0 2 2 2	
	31. DATE FILEO (Month, Day, Year) 32. REGIST	RAR'S SIGNATURE	10 Whallor	7 12 (Arhon	~ 2010K	
1	MAY 04 1995 Julia d	andra Revolate					



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מער ושום ודי	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be
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	PITA	ERA	77	Ξ
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	2	2	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Ξ

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H			GIENE 3. NO.	
	1. DECEOENT'S NAME (First, Middle, La	(81)	. 1			2. DATE OF DE	ATH	3. TIME OF DEATH
	John	REMONT DO	cott			April	20 C	25 2010 OM
	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR (Month, Day,		8. BIRTHPLACE (State or Foreign Country)
	187 - 22-3435	1 🔀 M 2 🗌 F	64 YRS.	MONTHS DAYS	HOURS MIN.			Pennsylvania
~	Se. FACILITY NAME (If not institution, gi	ve street and number)		9b. CITY, TOWN	OR LOCATION OF D			NTY OF DEATH
P	Shady Grove Ad	<u>ventist Hospit</u>	tal	Rock	ville		Mo	ntgomery
DIRECTOR	10a. STATE 10b. COU			Y, TOWN OR LOCA	TION			10d. INSIDE CITY
	Maryland M	ontgomery	(Germantov	wn			LIMITS?
\ ¥	10a. STREET AND NUMBER			10	f. ZIP CODE		10g. CITI	ZEN OF WHAT COUNTRY?
FUNERAL	18925 Abbotsfo	rd Circle			20876		Uni	ted States
E	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I			ENDENT OF HISPA		Ify Yea or No-	14. RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		2 X NO Specif		,	Specify:
8	15. DECEDENT'S E	DUCATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND	OF BUSINESS/IND	White
H.	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 8+)	(Give kind of v	work done during mo se retired.)	ost of working			
COMPLET		5+	Tea	cher			Seconda	rv
8 8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, I		
BE	John	Scott				Alice	Anne J	ones
2	19a. INFORMANT'S NAME (Type/Print) Joann N. Scott				and Number or Rural			
	20a. METHOD OF DISPOSITION	Jan	. PLACE AND DATE					Maryland 20876
	1 Burlel 2 Cremation 3 R	emoval from State	netery, crematory or o	ther plece)	ator:			City or Town, State ia, Virginia
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	500		ND ADDRESS OF FA			
	▶ //	(/) (0	cliva	4			1 Funer	
	23. PART L Enter the diseases,	or complications that cause	d the death. Do n	11.U E.D	eer Park	Dr., Ga	litherst	ourg, MD. 20877
	anock, or neart fellul	re. List only one cause on e	ech line.	or officer the file	de or dynig, add	ii aa caruioc or	reapiretory arr	Interval Between
	IMMEDIATE CAUSE (Final disease or condition	As the		1	r=1-			Onset and Daath
	reaulting in death)	DUE TO (OR AS /	CONSEQUENCE OF	J:	-Gan			Minufes
Z	Sequentially list conditions,	a. Acute DUE TO (OR AS A	Arte	n d	1sease			Vents
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	CONSEQUENCE OF	n: /				/
일	CAUSE (Disease or Injury that Initiated events	c. DUE TO (OR AS /	CONSEQUENCE OF	n.				
E	resulting in death) LAST			,				
	DART II Other elevitions and its							
ह	PART II. Other algnificent condit	- Unsculor d		n the underlying	g cause given in		AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	- Periplum	- Unsculor a	isease			101	ES 2 NO	OF DEATH?
Σ	DID TOBACCO USE CON	ATDIDLITE TO CALLEE C	E DEATH VE	C FOLIO F	I III ICEDTA			1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	S NO C	UNCERTAI	и Ц		
PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outp	7	OTHER:	e 5 🗆 flasidence	e 🗆 Other (Co)		
Ě	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	26b, TIM	E OF 28c INJ	URY AT		OW INJURY OCC	CUREO
ВУБ	1 Natural 6 Pending 2 Accident Investigation		INJ		PRK?			
	3 Suicide 6 Could not		— At home, term, a	treet, fectory, offic	•	281. LOCATION (S City or Town,	Street and Number State)	or Rural Route Number,
	4 Homicide detarmined							
COMPLETED		YSICIAN: To the best of my know						
ő	2 MEDICAL EXAM	INER: On the basis of exemination	n end/or investigatio	n, in my opinion, d	eath occured at the	time, date and pla	ce, and due to the	e cause(s) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIF	7			29c. LICENSE NUI	MBER	29d. DATE	E SIGNED (Month, Day, Year)
01	30. NAME AND ADDRESS OF PERSON	The state of the s	<u> </u>		441818		m	ay 1,1995
	PAL- 14	WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,			>		/
	31. DATE FILED (Month, Day, Year)	32. REGISTION'S SIGN	ATURE.	MAIN	St.	nucha	zus	MD, 20973
	MAY 04 199		x Rarball					ł
الــــا	11171 - 100							DHMH-16 Rev 1/89



e hospital or attending physician.	etached for use as the burial-transit permit. Pages 1, 2, 3 should	mea.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #6 5/4/95 MRT Montgomery Co 1 - STATE STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

County 5564

	REGISTRAR		CERTIFIC	ATE OF DE	ATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) HENRIETTA	SAN	IAKOW			2. DATE OF DEATH MONTH DA	9	YEAR 3.	TIME OF DEATH
	496-05-9128	1 - M 2 XF 78	The transfer of the transfer o				916		ACE (State or Foreign OHIO
TOR	90. FACILITY NAME (If not institution, give st HEBREW HOME OF DECEMENT			ROCKVIL		тн	9c. COUNTY MONT		
DIRECTOR	10e. STATE 10b. COUNTY	ONTGOMERY		OWN OR LOCATION VILLE					d. INSIDE CITY LIMITS 7 T YES 2 NO
FUNERAL	100. STREET AND NUMBER 6105 MONTROS	E ROAD		10f. ZIP C 2085			10g. CITIZEI UNITE		TATES
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	13. WAS DECENDEN If yes, specify C 1 YES 2 I	uben, Mexican,	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No- 14	Black, W	American Indian, white, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re SECRETA	done during most of wo tired.)	orking	166. KIND OF BUS	20124-00-24		JT
	17. FATHER'S NAME (First, Middle, Last) UNKNOWN	KAHN			ORA DA	E (First, Middle, Meiden		QVIII.	11
) BE	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Town	n, State, Zip Co	ode)	
2	DIANE LEVANT	(NIECE							LAND 21774
	20e METHOD OF DISPOSITION 1 (A Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State 20	b.PLACE AND DATE OF D	PISPOSITION (Name of Place) EMMES)	CATION — CIN INGTON		
	21. SIONATURE (MANUFACTURE ALC	ENSEE			Y-GOLD	GERG MEMO			ELS INC. ARYLAND 208
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF):	scu la	h (lcuiol	ent		
	PART II. Other aignificent conditions	e contributing to death	but not resulting in t	he underluing cour	o chies la D	ert i. 24e. WAS AN		Lautin	
MEDICAL		- Contributing to doubt	out not resulting in t	ne underlying cous	e given in Fa	PERFOR	MED?	AM CC DF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
	DID TOBACCO USE CONTR	IBUTE TO CAUSE (CERTAIN	1			
Sici	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (THER:	06 - FOOT T-VI				
T VES 2 No. 1 Inpetient 2 ER/Outpetient 3 DOA Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY					RED				
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, stc. (Spe	Y — At home, farm, street polity)	t, factory, office	-	201. LOCATION (Street a City or Town, State)	nd Number or	Rural Rout	e Number,
COMPLETED		CIAN: To the best of my known in the best of my known in the best of examination.						ause(a) an	nd manner se stated.
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER 1 SECTION OF PERSON WHO	mury	MD	I	357	79/	29d. DATE SI	IGNED (M	onth, Day, Year) 9/95
	MERIAN VEM	COMPLETED CAUSE OF DI	9801 GEL	RGIA.	AVE	SILV	EIC S	PKI	106
	MAY 04 1995	32. REGISTRAR'S SIGN				,	MP) 2	0902



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY 2, 1995 BEN SCHIFFMAN 4:23AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DEC. 6, 029-10-0935 1 X M 2 - F 75 MASSACHUSETTS YRS. 1919 permit. Pages 1, 2, 3 should $M_{\,\bullet}\,E_{\,\bullet}$ 9a. FACILITY NAME (If not institution, give street and number 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH HOLY CROSS HOSPITAL DIRECTOR SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? e as the burial-transit p 10221 CONOVER DRIVE 20902 UNITED STATES 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried Specify: WHITE BY 3 Widowed 4 Divorced ED R. JOHN 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET the hospital or Elementary/Secondary (0-12) College (1-4 or 5+) 4 ACCOUNTANT GOVERNMENT/PRIVATE be detach DR. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) JACOB SCHIFFMAN retained by BE **JENNY** (UNKNOWN) ED BY I 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 DOROTHY SCHIFFMAN (WIFE) 10221 CONOVER DRIVE-SILVER SPRING, MARYLAND 20902 9 Раде 6 тау 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State al. RELEASE examiner must Burtal 2 funeral director, KTNG DAVID MEMORIAL GARDEN 5/4 FALLS CHURCH, VIRGINIA ERAL SERVICE LIC 21. SIGNATURE OF F DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 the removal. medical and completely filled in by burial, cremation, or rema or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate ure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition_ Ischame Cardumy event, resulting in death) OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION and Sequantially list conditions, 0 the attending physician Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury attouselente other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO been signed by the any COMPLETION DF CAUSE 1 - YES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate I hours after death with the State **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inpatient 2 | FR/Outpatient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) 0 27. MANNER OF GEATH 28s. OATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCUREO marked, Netural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide Tem OR CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. HOSPITAL C FUNERAL C WITHIN 72 h TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: II II 2 MEDICAL EXAMINER: On the basis of a ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) MAY 2, 1995 2 OF DEATH (ITEM 27) (Type, Print) 20817

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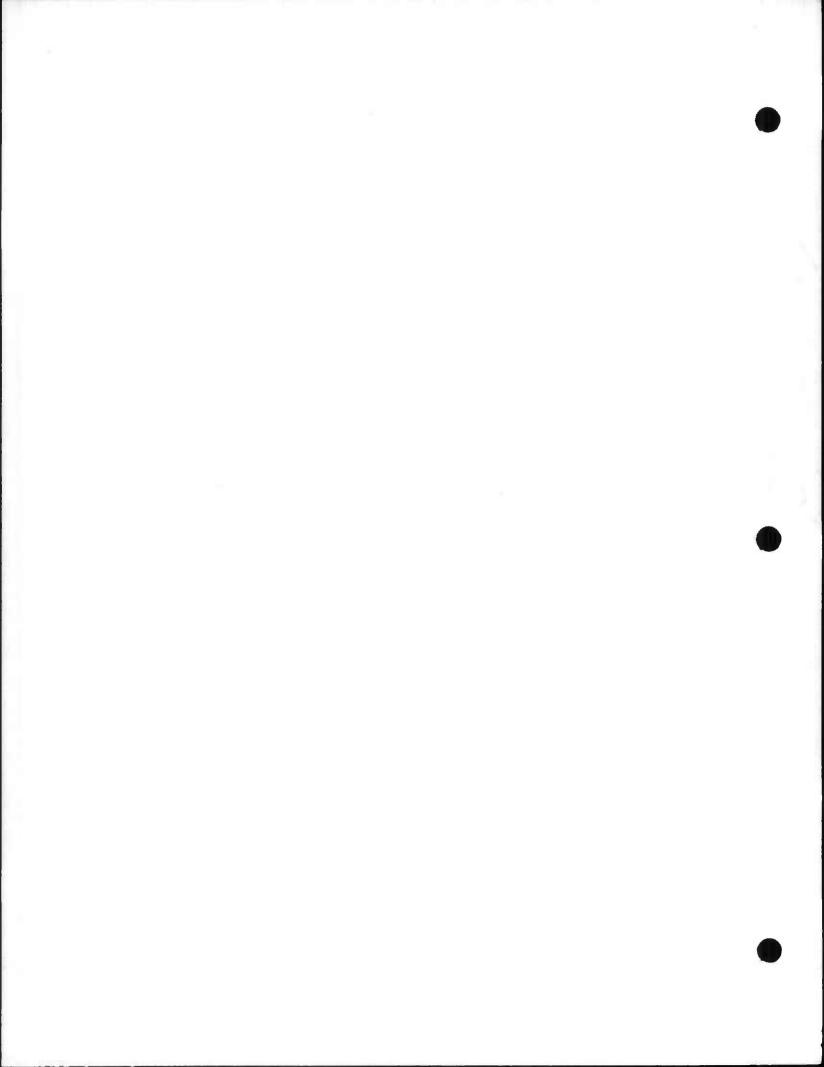
3amur 1 31. DATE FILEO (Month, Day, Year)

Goldboro

32. REGISTRAR'S SIGNATURE

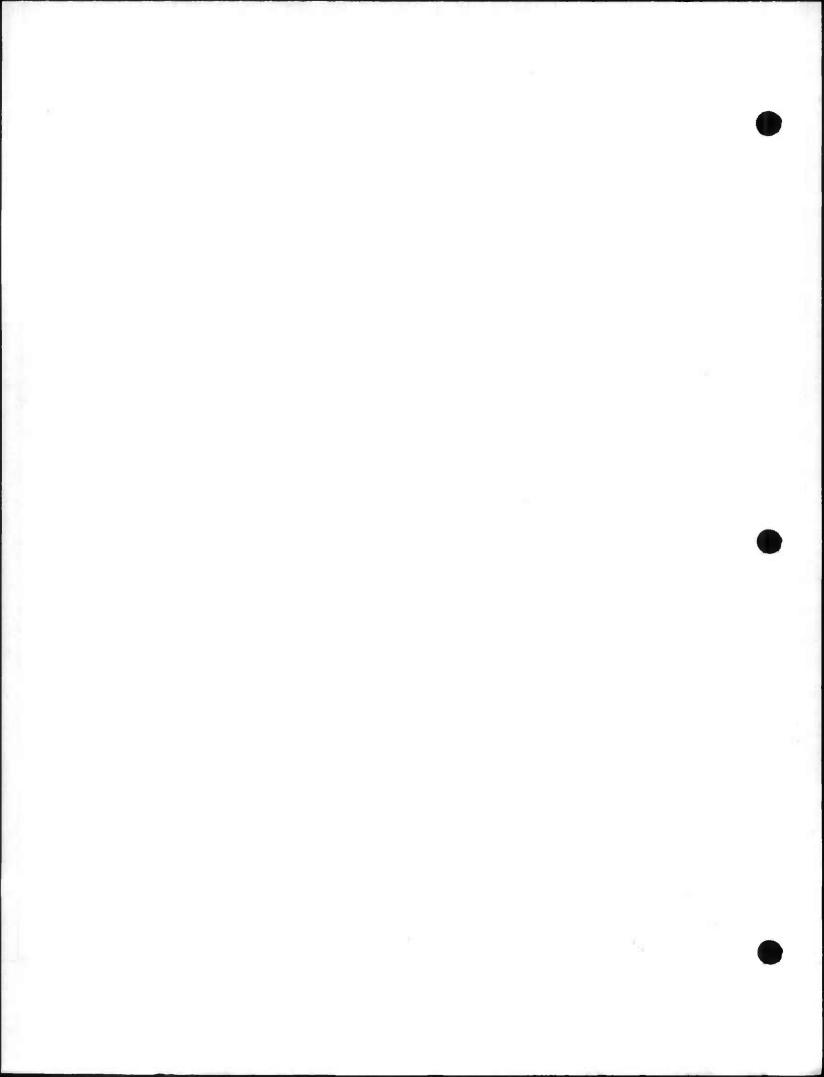
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DHMH-18 Rev 1/89



	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
RAR	CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF H	IEALTH AND I	MENTAL HYGIEN		
10		1. DECEDENT'S NAME (First, Middle, Last) Alexander	Vincen		karulis		2. DATE OF DEATH MONTH 3,		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		THPLACE (State or Foreign
9		052-12-4340	1 💢 M 2 🗌 F	75 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 06-12-191	Cou	CT
3 should	œ	9a. FACILITY NAME (If not institution, give sti	·			OR LOCATION OF DE		9c. COUNTY OF	
o,i	CTO	Harford Memoria	ai Hospitai		на	vre de C	race	Ha	rford
permit. Pages 1,	DIRECTOR	MD 10a. STATE 10b. COUNTY	Harford	10c. CI	ry, town on Locat	vre de (Grace		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
isit per	BAL	100. STREET AND NUMBER 211 Tidewater	Drive		101	21078		10g. CITIZEN OF	WHAT COUNTRY?
physician. burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER II			ENDENT OF HISPAN	HC ORIGIN? (Specify Yea	or No.— 14. RA	CE American Indian
attending phy ise as the bur	BY	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YES			2 NO Specify		Sp	white, etc. White
or att	ETED	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	S USUAL OCCUPATION Work done during me use retired.)	ON st of working	16b. KIND OF BUS	SINESS/INDUSTRY	
bed	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Quality	Control	Enginee	r Defe	ense Co	ntracting
the hor detach	S	17. FATHER'S NAME (First, Middle, Lest)	CI II				ME (First, Middle, Malden		
ould be	BE	Alexander 19a. INFORMANT'S NAME (Typo/Print)	Skarulis	105 MARIN	ADDRESS /Ormat		ana Y	annis	
be retained ge 5 should e notified	욘	Mrs. Mary H. Ska	erulis						MD 21078
may or pa		20e, METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b	PLACE AND DATE	of disposition (Ne	erne of		CATION — City or	
		21. SIONATURE OF FUNERAL SERVICE LICE		C. LIIII	22. NAME AN	D ADDRESS OF FA	CILITY		Grace, MD
		Wolan &	2 miles		Mitch Havr	iell-Smith e de Gra	n Funeral	Home, F 21078-3	P.A. 197
filled in		23. PART i. Enter the diseases, or canock, or has t feliure. L IMMEDIATE CAUSE (Fins) disease or condition	lat only one causa on e	ach iina.			h sa csrdiac or respi	iratory arrest,	Approximate Interval Batween Onset and Dasth
completely fille ial, cremation,		resulting in death)		CONSEQUENCE		3ca3c			i nr.
and o bur	NO.	Sequantielly list conditions,	ASCVD DUE TO (OR AS A	CONSEQUENCE	In:				
be sian	ERTIFICATION	If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury.							
death certificate attending physic ental Hygiene pri	HE	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE C	NF):				
0 . 6	CE								
that ed by th an	EDICAL	Hypertension, S			in the underlying	g cause given in	Part I. 24s. WAS AN PERFOR	MEO?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: The law requires the certificate has been signed in the State Dept, of Health if, or item 23 shows any	Σ	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF	DEATH Y	ES NO	X		1 YES 2 NO
V: The law icate has t State Dept item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Ch			
ician: ertifica the St	IXSI	1 X YES 2 □ NO 27. MANNER OF DEATH	1 ☐ Inpetient 2 X ER/Outp	atlent 3 DOA	4 - Nursing Hom		6 Other (Specify)		
DING PHYS After this death with	ву р	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	(IN	M 1 1	PRK? YES 2 NO	28d. OEŞCRIBE HOW I	NJURY OCCURED	
OR ATTENDING DIRECTOR: After hours after death tem 28 is mail	ETED.	3 Suicide 8 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Spec	— At home, tarm,	atreet, factory, offic		281, LOCATION (Street a City or Town, State)	and Number or Rura	Il Route Number,
로 국 전 는	COMPL		CIAN: To the beat of my known. C: On the beals of examination						e(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within ?	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Mh			29c. LICENSE NUN			3, 1995
F F Z €	5	30. NAME AND ADDRESS OF PERSON WHO							
		G. S. Prabhu, M.	D., 1810 Be	APPREA	, #102, I	-allston,	MD 21047	, 410-87	79-6564
		MAY 0 5 1995	12. REGISTRANS SIGN	Kardal					



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DIVISION OF VITAL RECORDS, P.O. BOX 68

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wife. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
MAY 0 4 1995

												95	15567			
	FOR 1 - STATE REGISTRAR	STATE OF 1	MARYLAND C	DEPAR	RTMEN	T OF H	EALTH DEAT	AND I	MENTA	L HYGIEN						
	1. OECEDENT'S NAME (First, Middle, Last)								2. DATE	OF OEATH			3. TIME OF OEATH			
	MARIE ANN	IE SHA	מסג						MONT	4 0	AY 1	YEAR	10:15a w			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	and defeate along		R 1 YEAR	IF UNDER		MAY	OF BIRTH	2 1	995				
				0.00	MONTHS	DAYS	HOURS	MIN.	(Monti	n, Day, Year)		Count	HPLACE (State or Foreign try)			
	214-28-8138	1 🗌 M 2 🙀 F	72	YRŚ.					APR	IL 7	,192	3	MD.			
	9a. FACILITY NAME (If not institution, give a				9b. CITY	r, TOWN O	R LOCATIO	ON OF OR	EATH		9c. COU	NTY OF	DEATH			
181	HOME- 11416 K	ITTY CO	DRNER B	RD.		CORD	OVA				1	TAL	ВОТ			
DIRECTOR	RESIDENCE OF DECEDENT			_												
#	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN	OR LOCATI	ION						10d. INSIDE CITY LIMITS?			
	MD	TALBOT			CCRI	OOVA							1 XYES 2 NO			
FUNERAL	10e. STREET AND NUMBER					101.	ZIP CODE	E			10g. CIT	IZEN OF	WHAT COUNTRY?			
E	11416 KITTY	CORNER	RD.				216	25				TT	SA			
151	11. MARITAL STATUS	12 WAS DECEDEN	T EVED IN ILE A	RMED	13.	WAS DECE	ENDENT C	F HISPAN	NIC ORIGIN	17 (Specify Ye	s or No—		E — American Indian, ik, While, etc.			
	1 Never Married 2 Married	FORCES? 1	YES 2 T	WO.		If yes, spe	city Cuba	n, Mexica	n, Puerto I	Rican, etc.)						
<u>&</u>	3 Widowed 4 Divorced	",	THE DATE OF			1 1 163	2 1/2 140	Specify	y .			арис	BLACK			
	15. OECEDENT'S EDU	CATION	16a, Di	ECEDENT'S	USUAL O	CCUPATIO	N		16b	KIND OF BU	SINESS/INI	DUSTRY				
151	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	ii	Give kind of e. Do NOT u	work done se retired.)	during mos	t of working	ng								
1 2	0.7	Conege (1-4 pr 3		ABO	GTG					אסת	MEST	TC				
COMPLET	17. FATHER'S NAME (First, Middle, Last)			JADO.	V IS IX		18 MOTI	MED'S NA	ME /First /			10				
		חששם								t, Middle, Maiden Surname)						
8		RTER		-				NANI		GIBS						
2	19a. INFORMANT'S NAME (Type/Print)		15	9b. MAILING	ADDRES	S (Street an	nd Number	or Rural I	Route Numi	ber, City or Tow	vn, State, Zij	Code)				
-	KATIE MURRAY			64	40 F	BELL	EVUI	E RI) R	OYAL	OAK	MD	21663			
1 1	20a. METHOD OF DISPOSITION Surial 2 Cremation 3 Ram	oval from State	20b. PLACE				ne of		OAT		CATION -					
Cemetal 2 Cremation 3 Ramoval from State Cemetary, crematory or other place) ST. STEPHENS CEMET. 5/6 EASTON, MD									D.							
21. SIGNATURE OF FUNELY. SERVICE LICENSIA. 22. NAME AND ADDRESS OF FACILITY																
FOOKS FUNERAL SERVICE																
Н	Norsell 1	7 100			3	19	E. I	DOVE	ER S	T. E.	STO	N.M	0.21601			
1 1	23. PART I. Enter the diseases, or ahock, or heart fellure.	complications the	it ceused the duse on each lin	eath. Do	not enter	r the mod	de of dyl	ing, suc	h aa carc	liac or reap	iratory en	reat,	Approximate Interval Between			
1 1	IMMEDIATE CAUSE (Final	01.0		An.		211						.1	Onset and Death			
	disease or condition resulting in deeth)	PAOS	HBUE	21 CH	TE (CVA						HO	URS			
		DUE TO	(OR AS A CONSE	OUENCE O	F):	-										
z																
RTIFICATION	Sequantielly list conditiona, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE O	F):											
I A	cause. Enter UNDERLYING															
E	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSE	OUENCE O	F):											
E	resulting in death) LAST															
S		d														
	PART III Other algorificent condition	a contributing to	death but not	resuiting	In the u	nderlying	ceuse g	given in	Part I.	24a. WAS AP		241	. WERE AUTOPSY FINDINGS			
MEDICAL	HTN									PERFO	RMED7		AMAILABLE PRIOR TO COMPLETION OF CAUSE			
										1 1 763	X NO		OF DEATH?			
Σ				_					-				1 TYES 2 NO			
SICIAN:	OF WAS CASE DEFENDED TO MEDION															
o o	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF D	EATH (Ch	eck only or	10)						
1 VES 2 NO 1 Inpettent 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)																
27. MANNER OF DEATH 27. MANNER OF DEATH 28. OATE OF INJURY (Morith, Dey, Year) 28. OATE OF INJURY (Morith, Dey, Year) 29. TIME OF INJURY WORK? 1 YES 2 NO 28. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO								CURED								
	3 Suicide 8 Could not be	28a. PLACE C	OF INJURY — At h. etc. (Specify)	ome, farm,	street, lac	tory, office						r or Rural	Route Number,			
ETE	4 Homicide delarmined		- (46,000)						City	or Town, State	,					
	290. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the heat of	my knowledge d	lagth account	and no etc.	lime al-a-	and -!	004.4	to the	unale) == 1		de d				
COMPL	the second secon	CIAN: To the best of											s) and manner as stated,			
8	1/ 1	/		vestigati	en, nt my	opinion, de	retti OCCUI	eu at trie	rime, data	ena piace, e	oue to I	IA CERSO(e) and manner as stated.			
ш	296. BIGHATURE AND TITLE OF CENTERIN	0///	1.				29c. LICI	ENSE NUM	MBER	2	29d. DAT	E SIGNE	O (Month, Day, Year)			
0 8	angel	4/2 N					DE	52	25	1	1	5-4	1-45			
I F II	30, NAME AND ADDRESS OF PERSON WH	D COMPLETED CAU	SE OF DEATH /IT	EM 27) (Turn	Delet)							7	1			

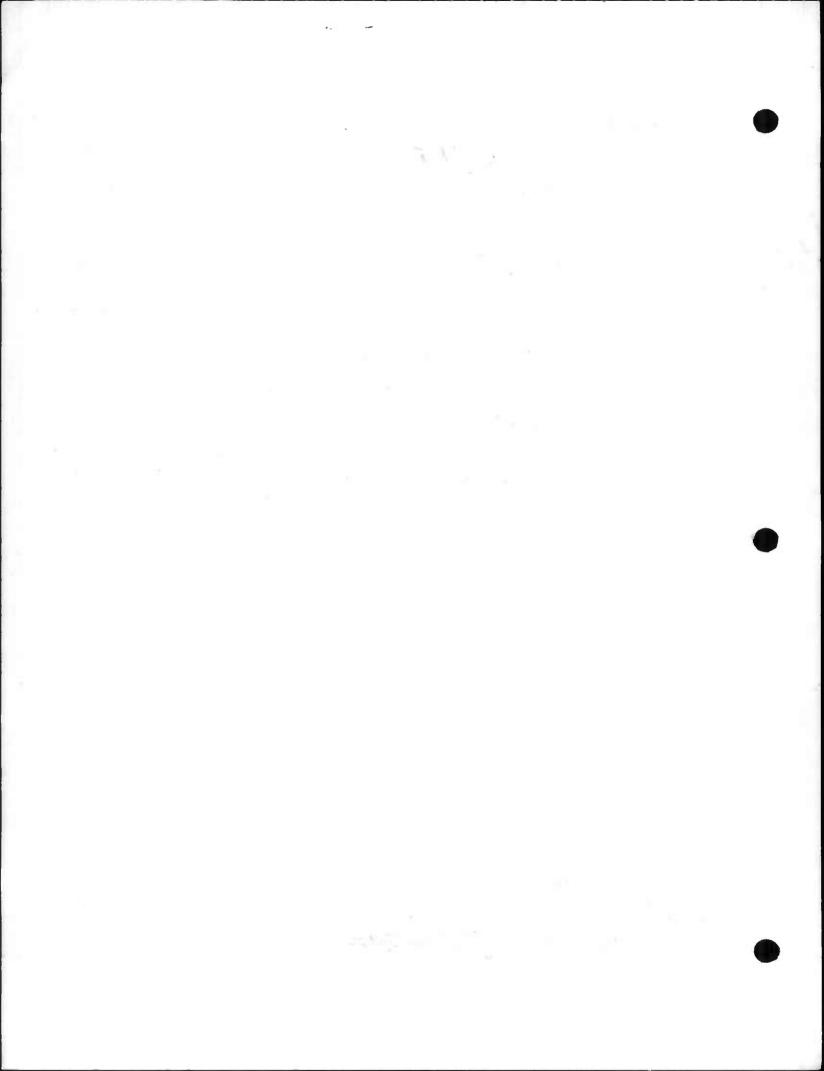
CAUSE OF DEATH (ITEM 27) (Type Print)

COCO OUT OUT MANY LANGE

32 AEGISTBAR'S SIGNATURS

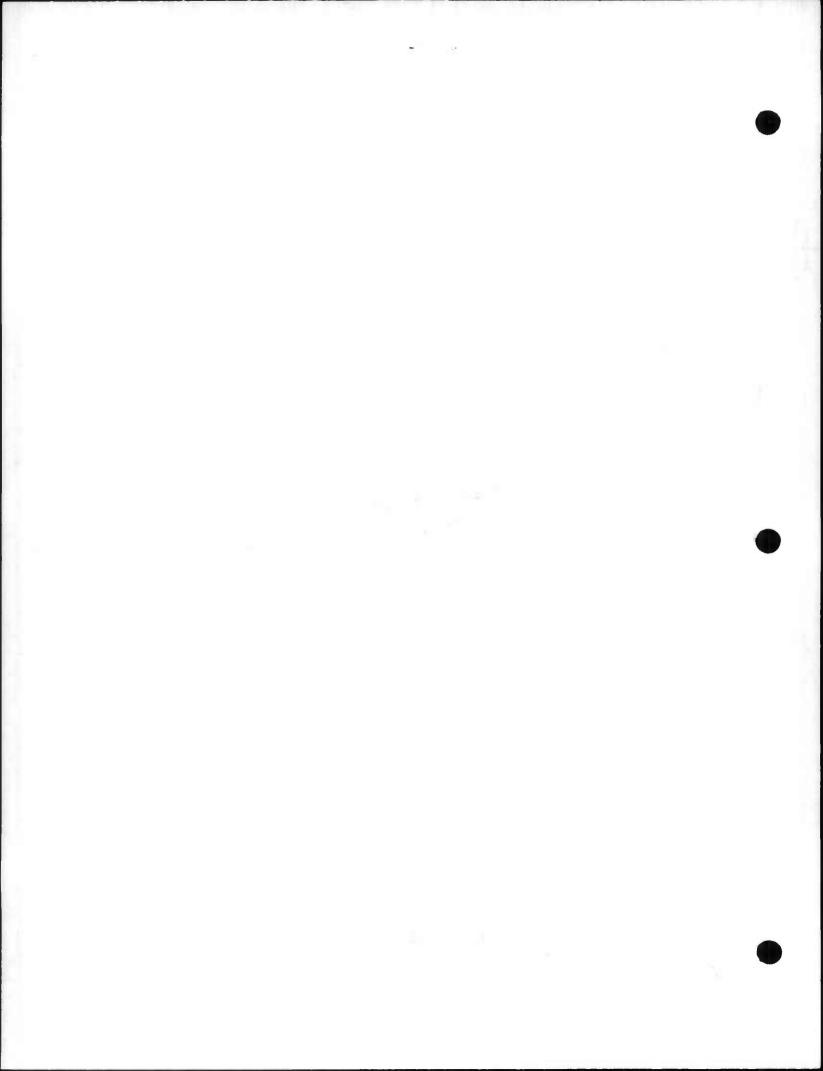
14, 1111

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last) PAULETTE V, SAUNGERS 2. DATE OF DEATH MONTH DAY VEAR 11- A. M							
2		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 X F YRS. MONTHS DAYS HOURE MIN. AUG 261949 Country)							
2, 3 should	ЕСТОВ	98. FACILITY NAME (If not institution, give street and number) 94 \$55 AT THE HOME OF MOTHER POPILIVE. CHESTER TOWN RESIDENCE OF DECEDENT 96. COUNTY OF DEATH RESIDENCE OF DECEDENT							
t. Pages 1,	DIREC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Che.STER TOWN 10d. INSIDE CITY LIMITS? 1 yes 2 Kno							
n. ansit permit.	3AL	100. STREET AND NUMBER 7513 SUNBURSTAVE 101. ZIP COOE 2,1620 109. CITIZEN OF WHAT COUNTRY? 2,1620 U. S.A							
5-0020 Inding physician. as the burial-transit	BY FUNER	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— 15. Never Married 2 Merried 16. Was Deceded Tever in U.S. ARMED 17. Was Deceded Tever in U.S. ARMED 18. Was Deceded Tever in U.S. ARMED 19. Was Deceded Tever in U.S. ARM							
D 2121 spital or atte	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) D = 12 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) F/* ShTATE HANT A ! R - L ! N E							
YLA by the be del		17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) WILLIAN C NAKIES SAUNDERS VINAN JOHNSON							
MAR retained 5 should notified	TO B	192. INFORMANT'S NAME (Type/Print) 195. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7485 RORIAN AVE, CVIESTER TOWN, N. 2, 620							
IMORE, Page 6 may be Il director, page		20e. METNOD OF DISPOSITION 1 Burlai 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) C METERY Text C METERY Text							
SALT death. he funera al.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 22. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 24. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 25. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 26. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 27. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 28. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 29. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 20. TO CHESTER TO WHY MID 21. SIGNATURE OF FUNE KILL HOME 22. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 23. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 24. CHESTER TO WHY MID 25. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 26. NAME AND ADDRESS OF FACILITY S1. CHESTER TO WHY MID 27. CHESTER TO WHY MID 28. CHESTER TO WHY MID 28. CHESTER TO WHY MID 29. CHESTER TO WHY MID 29. CHESTER TO WHY MID 29. CHESTER TO WHY MID 29. CHESTER TO WHY MID 20. CHESTER TO WHY WHY WHY WHY WHY WHY WHY WHY WHY WHY							
within 24 within 24 pletely fill cremation.		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, enterty enterty errest, enterty enterty errest, enterty enterty errest, enterty							
P.O. BOX 68 th certificate be executed from the ending physician and a Hygiene prior to bur or other traumatis.	ERTIFICATION	Sequentielly list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.							
OKDS, It that the death hed by the atte th and Mental any injury,	AL C	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH?							
WEC v requires been sign t, of Hea shows	ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
The He He	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO							
DING PHYSIC After this cer death with th	BY PH	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28d. DE\$CRIBE NOW INJURY OCCURED							
TTENDI TTOR: A after de	8	3 Suicide a Could not be detarmined detarmined detarmined detarmined a large state of the suicide detarmined d							
4 12 E	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, and due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.							
TO THE HOSPIT TO THE FUNERA be filed within 7 IMPORTANT: I	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 16 (Collins Mis). 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 17 2/3/3 18 4/21/95							
	15	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KINKUE WUN 216 HIGH SC. Chesterlaw, Md. 21620							
		31. DATE FILED (Month, Day, Year) 32. REGISTRAT'S SIGNATURE APR 25 '95 APR 25 '95 APR 25 '95							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
_
be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.
IMPORTANT If then 28 is marked or them 23 shows any injury or other transmatic event the medical avenues he marked or new

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	Lawrer	nce E	dward	Slagle	Sr.	May 4	1995					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. Bi	RTHPLACE (State or Foreign				
	217-16-9648	1½ M 2 □ F 70	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) May 22, 192	,	arvland				
	9a. FACILITY NAME (If not institution, give st				OR LOCATION OF E	DEATH	9c. COUNTY O	F DEATH				
5	The Kent and Queer	i Anne;s Hosi	pital, li	1C	Chestert	.own	Ken	t				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	/, TOWH OR LOCA	TION			10d, INSIDE CITY				
H	Maryland	Kent	100	Cl	nesterto			LIMITS?				
	10e. STREET AND NUMBER	110110			1. ZIP CODE	WII	10g. CITIZEN C	OF WHAT COUNTRY?				
FUNERAL	822 High Street				21620		United	States				
Ę	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 X YES	N U.S. ARMED			NIC ORIGIN? (Specify Ye	s or No — 14. R	ACE — American Indian, llack, White, etc.				
BY I	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES	2 NO Spec	an, Puerto Rican, etc.) #y:		pecify:				
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S	HELIAL OCCUPATI	011			White				
ET 1	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)		rork done during mo		160. KIND OF BU	SINESS/INDUSTR	Y				
PL	10	Conege (1-4 or 5+)	Electri	cian		Cont	ract					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			O-LUIT	16. MOTHER'S N	AME (First, Middle, Meiden						
1 144	William E. Slagle				Anna :	Stevens						
TO BE	19a. INFORMANT'S NAME (Type/Print)	01 1				Route Number, City or Tow)				
	Mrs. Charlotte E.		822 Hi	gh Stree	et, Ches	tertown, Ma	ryland	21620				
	20a METHOD OF DISPOSITION 1 Description 2 Grammation 3 Ramo	oval from State gen	D. PLACE AND DATE Onetery, cremetory or oti	her niscel		DATE 20c. LO	CATION City of	r Town, State				
	4 Donation 5 Other (Specify)	ENSEE LINE	ster Cemet			Chest	ertown, M	faryland				
William I Vine Ld 4/ Fellows - Wells Funeral Home												
		1.00776	d'ann	413 W	est High S	treet, Cheste	rtown, Ma	aryland				
	23. PART I. Enter the diseases, or complications that disease the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line.											
	IMMEDIATE CAUSE (Final											
	disease or condition resulting in death) a. BILUTTEMBY BY CUITE INTERMEDIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):											
	_	al Imaga La	CONSEQUENCE OF):) : 4 (15.100				
Ó	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	u num	YPISOMSO	ř	(071)				
8	cause. Enter UNDERLYING CAUSE (Disease or Injury											
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	reaulting in death) LAST	1.										
AL C	PART II. Other algnificant conditions	contributing to deeth b	out not resulting in	n the underlyin	g ceuse given in	Part I. 24s. WAS AN	AUTOPSY :	24b. WERE AUTOPSY FINDINGS				
1 4						PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE				
MEDIC							7,10	OF DEATN?				
z	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S X NO C	UNCERTAI	N 🗆						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT									
YSi	1 VES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)											
표	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF UNDERLY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY											
BY	1 privatural 5 Pending 2 Accident Investigation M 1 YES 2 NO											
ETED	3 Suicide 6 Could not be determined 4 Homicide determined 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)											
Ē	29a. CERTIFIER											
COMPL	(Check only	CIAN: To the best of my know										
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law mountain the death certificate be executed within 4 hours after death. Date 6 may be remained by	TO THE FUNERAL DIRECTOR: After this certificate has been some by the attending physician and completely filled in by the funeral director name 5 should have	be filed within 72 hours after death with the State Dept. or Hearth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If item 28 is marked on item 23 shows any injury or other traumatic event the medical avergines must be motified as

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	1 - STATE REGISTRAR	STATE OF MA	ARYLAND C	DEPAR	RTMENT O	F HEALTH	AND	MENTAL	HYGIEN REG. NO				
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8	39 Black Hill Ro					wn or locat th Eas	11,000					Cil	
<u>ප</u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	-											
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BE	Gustav A. Stenro	os						lund					
0	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Str	eet end Numbe	r or Rural I	Route Number	City or Town	n, State, Zip	Code)	19335	
-	Arnold J. Sten		4	412 L	ightfo	ot Dri	lve,	Downi	ngtov	m, P	ennsy	lvania	
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ren	oval from State	20b. PLACE	b. PLACE AND DATE OF DISPOSITION (Name of					DATE 20c. LOCATION — City or Town, State				
	1 N Burlet 2 Cremation 3 Removal from State commetery, crematory or other place) 1 Donation 5 Other (Specify) North East Methodist Cem. 5/6 North East, Mary 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	//										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, ahock, or heart failure. List only one cause on each line.											MD 2190		
CERTIFICATION	Interval Between Onset and Death MMEDIATE CAUSE (Final disease or condition resulting in death)												
ERT	resulting in death) LAST												
PHYSICIAN: MEDICAL (PART II. Other algnificant condition						_ ¹	Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO			WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? VES 2 NO		
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Ö	2 MEDICAL EXAMINE	:H: On the beele of exar	nination end/or	investigatio	n, in my opinio	n, death occur	red at the	time, date en	d place, en	d due lo the	e cause(e)	end manner ee stated.	
ш	296. SIGNATURE AND TITLE OF CONTIFIE					29c. LIC	ENSE NUM	BER		29d, DATE	SIGNED (Wonth, Day, Year)	
TO B	ON P.					D.	-3239	95		▶ Ma	y 5.	1995	
F	Dr. Thomas Finu					h Eac	t. МТ	219	001		287-		
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	MAY 0 5 1995	Tulia Develso	-Kardall										

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed writing. Figures are death. Page to may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the bunal-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Isom 28 is marked or Isom 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Thomas Finucan, M.D.

31. DATE FILED (MONTH, Day, 1987)

MAY 05 1995

STATE DOCOMETY DATE (If no interior and process of party Point Docomety Point Docom
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15. MOTHER'S NAME (First, Middle, Lear) John Sech 15e. MOTHER'S NAME (First, Middle, Maldles Survice) Annie Servick 15e. MOTHER'S NAME (First, Middle, Maldles Survice) Annie Servick 15e. MAILING Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280.9 Frazer Road, Newark, DE 19702 20c. METHOD OF DISPOSITION 10 Elaware Vets. Cem. 21c. NAME AND ADDRESS of FACILITY Beeson Memorial Services 22.1 NAME AND ADDRESS of FACILITY Beeson Memorial Services 22.2 NAME AND ADDRESS of FACILITY Beeson Memorial Services 20.5 Pulaski Hwy., Newark, DE 19702 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death of the Constitution
19b. MAILING ADDRESS (Street and Number or Rural Route Humbes, City or Town, State, Zip Code) ROSEMATIE Sech 20b. METHOD OF DISPOSITION 12B SURFIG 2 Cramation 3 Removal from State 1 Denation 5 Other (Specify) 21 BORNATURE OF FUNDAL SERVICE CERTISE 22. NAME AND ADDRESS of FACILITY 22. NAME AND ADDRESS of FACILITY 22. NAME AND ADDRESS OF FACILITY 23. PART I/Enter the disabress, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disabress, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, large and the state of
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Rosemarie Sech 2809 Frazer Road, Newark, DE 19702 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. LOCATION - City or Town, States 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other place) 20b. LOCATION - City or Town, States 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or other places 20b. PLACE OF DISPOSITION (Name of cemeter), cremetery or othe
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Beeson Memorial Services 2053 Pulaski Hwy., Newark, DE 19702 23. PART I./Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Cerebral Vascular Disease Due to (or As a consequence of): b. Multi-infarct Dementia Due to (or As a consequence of): c. Oue to (or As a consequence of): d. Due to (or As a consequence of): d. Due to (or As a consequence of): d. Due to (or As a consequence of): 1 Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRODING AMALALE PRIOR TO COMPLETION of CAUSE OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL BASED AND AND AND AND AND AND AND AND AND AN
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONS
25. WAS CASE REFERRED TO MEDICAL EXAMINER? PERFORMEO? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1
EXAMINER? HOSPITAL: OTHER:
EXAMINER? HOSPITAL: OTHER:
- Date - Date
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Pending Investigation 28a. DATE OF INJURY 28b. TIME OF INJURY WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED
3 Suicide 6 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Flural Route Number, City or Town, State)
29s. CERTIFIER Chart cols. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
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SZ. REGISTRAR'S AGNATURES

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3. TIME OF DEATH 3:50P"

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

MAY 0 9 1995

DIVISION OF VITAL RECORDS, P.O. BOX 687

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pino		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	last birthday)			IF UNDER		7. DATE OF BIRTY		8. BIRT	HPLACE (State or Foreig	
9		220-09-7/75 1 M 2 W 78 Yes. Aug. 6,1916								1916	6 Maryland				
3 should	~	9e. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 1.1 - 1													
6,	0	Washington County Hospital Hagerstown Washington													
permit. Pages 1, 2,	EC	40. CTATE 40. COUNTY												10d. INSIDE CITY	
Pag	DIRECTOR	Maryland Washington Hagerstown											LIMITS?		
ermi		10e. STREET AND NUMBER							H. ZIP CODE			10a, CI1	IZEN OF	WHAT COUNTRY?	
15	ER/	18351 College Road USA													
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r attending use as the	8	15. DECI	EDENT'S EOU	16a.	DECEDENT'S	DUSTRY	-								
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by the hospital or be detached for at once.	COMPLETED	17. FATHER'S NAME (First, Mi		18. MOTHER'S NAME (First, Mick											
should	BE (William Ben		Keefer							Elizabet				
	0	19e. INFORMANT'S NAME (7)				19b. MAILIN									
y be re sage 5 be no	-	Jerry L. Sp				18351 College Road, Hagerstown, Md. 21740									
leath. Page 6 may be funeral director, page xaminer must be		2L Buriel 2 Cremetion 3 Removal from State cemetery, crematory or other place)									c. LOCATION —	CATION — City or Town, State			
direct direct	l N	21. SIGNATURE OF FUNERAL SERVICE LIGHTING Smithsburg Cemetery 5-10-95 Smithsburg, Mar												Maryland	
death. Pag tuneral dir il.	1 1	22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME													
n by the furemoval.	ш	415 E.Wilson Blvd., Hagerstown, Md. 21740													
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th certificate be execute ending physician and coming thysiene prior to buria or other traumatic.	CERTIFICATION	Sequentially list condition if any, leeding to immediate. Enter UNDERLY!! CAUSE (Dissess or injusted events resulting in death) LAST	diete NG ry	DUE TO	(OR AS A CONS	SEOUENCE C	PF):								
the deaty the att		PART II. Other significan	nt condition	s contributing to	death, but no	t reaulting	jh the un	nderlyjn	g cause g	lven in P	ert I. 24a, WA	S AN AUTOPSY	246	. WERE AUTOPSY FINDIN	
requires that is seen signed by of Health and shows any I	MEDICAL	Hypotherine; Charle long belove 1 yes 2 th										AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO			
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certificate hat the State D	PHYSICIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL	ACE OF DEA									
	\S	1 YES 2 NO 1 Metient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Rasidence 8 Other (Specify)													
	F	27. MANNER OF DEATH	Pending	INJURY ay, Year)				JURY AT ORK?	1	ed. DESCRIBE HOW INJURY OCCURED					
NG PHYS ther this sath with marked	B⊀		nvestigation	,			M	1 🗆		NO NO					
DIRECTOR: After thours after death item 28 is mar	8		Could not be letarmined	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, tarm,	street, tect	lory, offic	:•	1	est. LOCATION (St. City or Town, S		or Rural I	Route Number,	
DIRECT POURS	9	290. CERTIFIER	EVING DHVE	NAM: To the best of	- hambet	4.54							_		
PAR PAR	COMPLET			CIAN: To the best of R: On the basis of e										s) end manner as stated	
HOSPITAL FUNERAL WITHIN 72(1)	1 - 11	296 SIGNATURE AND TITLE					,, 0	,							
THE HOSPI TO THE FUNER THE WITHIN	BE	Amust.	Chin	11 MAT					29c. LICE	NSE NUMB	255	29d. DAT	2/0	(Month, Day, Year)	
253	임	30. NAME AND ADDRESS OF	PERSON WW	COMPLETED ONLY	DE OF OPATION	rendad a	0.1		-	100			10	17.1	

CAUSE OF DEATH (ITEM/27) (Type, Print)

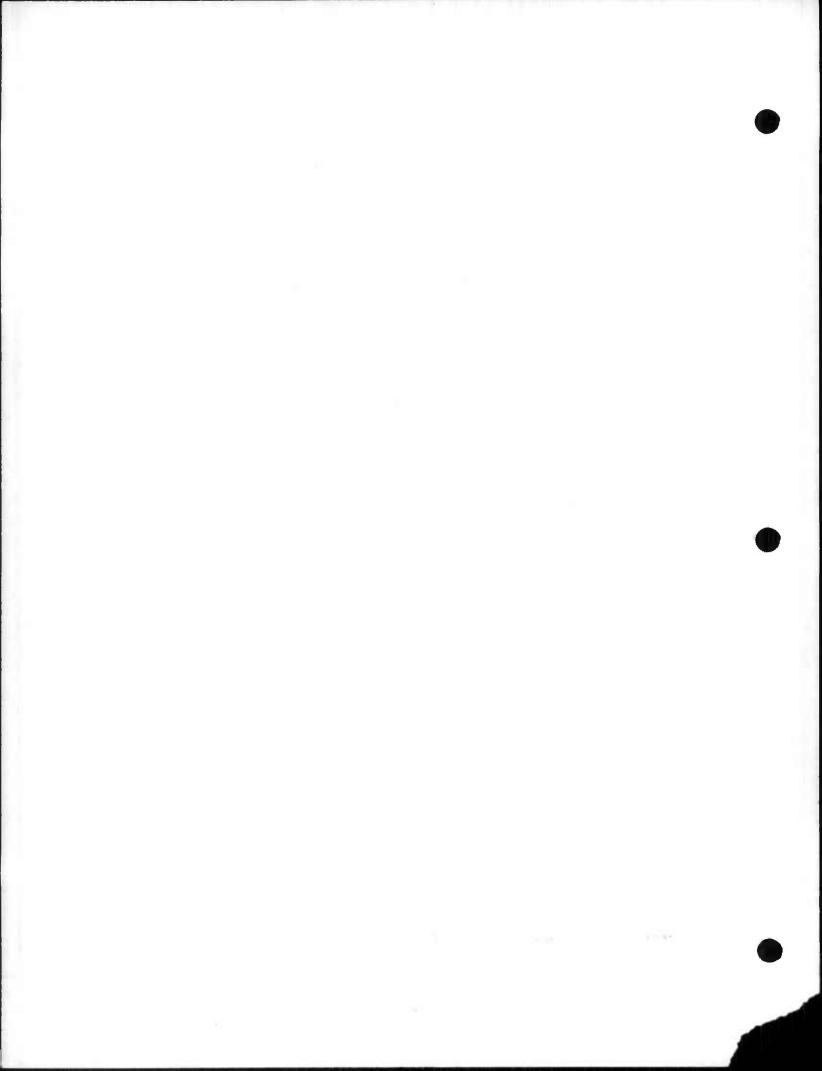
32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

2. DATE OF DEATH

24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 - NO INJURY OCCURED end Number or Rural Route Number, nner es stated. nd due to the cause(s) end manner as stated. 29d. DATE WEND (Month, Day, Year) DHMH-16 Rev 1/89

Approximete Interval Between **Onset and Death**



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DIVISION OF VITAL RECORDS,		
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

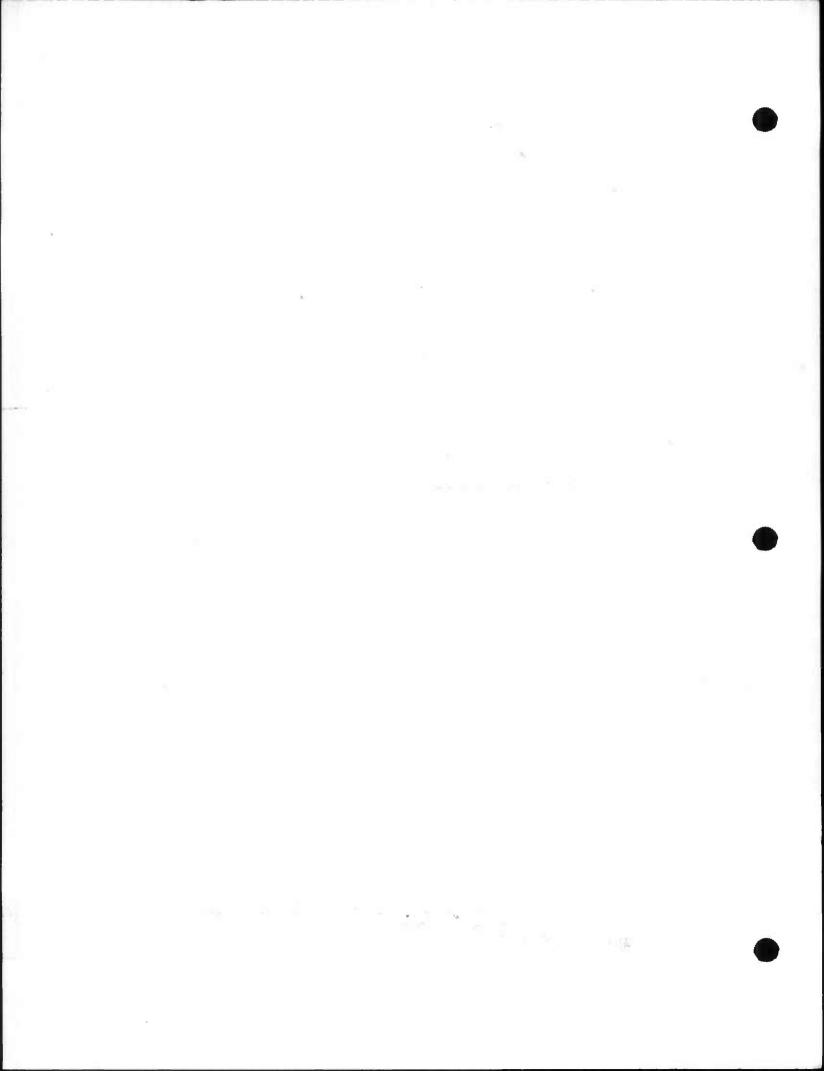
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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MAY 0 9 1995

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR		STATE OF I	MARVI	AND / D	EDADT	MENT	UE P	JEAITU	AND	MENTA	LUVCIEN	<i>)</i>	J	10010
1 - STATE REGISTRAR		OIAIL OI I	WAILL					DEAT		MENIA	REG. NO.	_		
1. decedent's name (First Rober		Lee		SF	PRAN	NKLE					y 8,	3. TIME OF DEATH 25 131 4 N		
4. SOCIAL SECURITY NUMBER	BER	5. SEX	8. AGE	(In yrs. last bli		IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS.	7. DATE	OF BIRTH		95 6. BIRTH	PLACE (State or Foreign
217-42-980		1 MM 2 □ F	4	9	YRS.					Jul	y 6,19		Mar	yland
9a. FACILITY NAME (If not in						9b. CITY,	TOWN	OR LOCATION	ON OF DE	EATH			UNITY OF DE	
12323 Mumm	ert Rd	•				C	lea	r Spi	ring			WA	SHING	TON
10e. STATE	10b. COUNTY	1		1	Oc. CITY,	TOWN OF	R LOCAT	TION						10d. INSIDE CITY LIMITS?
Maryland	Wa	shington			Cle	ar S	pri	ng						1 YES 2 NO
100. STREET AND NUMBER							101	f. ZIP CODI				10g. CI1		HAT COUNTRY?
12323 Mumm	<u>ert Rd</u>								722				USA	
11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	YES	2 X NO	D	lf.	yes, sp	ecity Cuba	n, Maxica	n, Puarto	N? (Specify Yea Rican, etc.)	or No-	14. RACE Black	- American Indian, White, atc.
3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR D	ATES		1	_ YES	2 NO	Specify	y:			Specif	White
	CEDENT'S EDU			16a. DECE	DENT'S U	SUAL OC	CUPATIO	ON		16	b. KIND OF BUS	SINESS/IN	DUSTRY	
Elementary/Secondary (College (1-4 or 5	+)	life. Do	NOT use	retired.)	uring mo	est of working	ng .					
12				Es†	<u>imat</u>	or					Black	top	Contr	ractor
17. FATHER'S NAME (First, M											Middle, Malden	_		
Robert		inton		Sprai	_				illi		Mar			ffsen
19a. INFORMANT'S NAME (nber, City or Town			22
Patricia		nkle	001	D. PLACE AND					a. C	_	Sprin	<u> </u>		
1 M Buriel 2 Cremetic 4 Donation 8 Dother	on 3 🗆 Reme	oval from State		netery, crematedar La					v 11	1005	TE 20c. LO		City or To	4D 21740
21. SIGNATURE OF FUNERA		egiste A		Judi Lai	WIT I'R			ND ADDRES			Triag	6131	OWII,	10 21740
► Misson	m	Valu		_		os	BOR	NE F	UNER	AL H	IOME			
23. PART I. Enter the d	isanaa or	complications the	t course	d the death							lliams			
strock, or h	eset fallurs.	List only ons car	ise on e	sch lins.	i. Do no	ot snisr t	ne mo	ias or ayı	ng, suc	n ss.csr	disc or respi	ratory sr	rrest,	Approximats interval Between
IMMEDIATE CAUSE (Fir disease or condition	nsi	/ lova	1.0	2	24/	241	4	west	-					Onset and Death
resulting in death)		BUE TO	(OR AS A	A CONSEQUE	NCE OF)	cry	-	100/						minuts
		Metas	tahi	A CONSEQUE	na	eat	C	Con	ux	•				į
Sequentially list condit if any, issding to imms				CONSEQUE										
Cause. Enter UNDERLY		c												
that initiated events resulting in death) LAS	т	DUE TO	(OR AS A	CONSEQUE	NCE OF):	:								
		d					_		<u> </u>	_				
PART II. Other significa	nt condition	s contributing to	desth b	out not resu	liting in	ths und	lerlying	g cause g	lven in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
											PERFOR	. 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE
												X		OF DEATH?
DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE O	F DEATH	YES	□ N	10 [UNC	ERTAIN	V D				
25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		26. PLACE O	_									
1 TYES 2 NO		1 Inpatient 2	ER/Outp	patient 3 🗆		OTHER:		6 5 Re	sidence	6 🗆 Oth	or (Specify)			
27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D		21	86. TIME INJUI	OF 2	28c. INJ WO	URY AT		28d. DE	SCRIBE HOW IP	NJURY OC	CURED	
2 Accident	Investigation					М		YES 2	NO					
	Could not be determined	28a. PLACE O building,	atc. (Spec	— At home, cify)	farm, str	reet, factor	ry, offici		i	281. LOC City	OATION (Street a or Town, State)	nd Numbe	or Aural A	oute Number,
29a. CERTIFIER														
(Check only		CIAN: To the best of R: On the best of a												
	7		AMPHITMENOI	o end/of INVe	engation,	, ит ту орі	wiion, d				and place, and			and manner as stated.
296. BIGHATURE IND TITLE	1 LV		>					29c. LICE	NSE NUN	ABER	=	29d. DAT	E SIGNED	(Month, Day, Year)
30, NAME AND ADDRESS OF	PERSON WILL	COMPLETED CAU	SE DE DE	ATM CITTURE 22	n /n n	bini 12 i	20	2)4	47	19		-0	3/0	7/73
, /- , '	MP	1110 11-1	Local	Came		-	32) IS	7	lager=	stou	UN M	1021740
31. DATE FILED (Month, Dec	YOU!	12 Redistre	TOO!	ATTHEMENT	1	r · ne	iger	stow	11 7 1410	217	40			
M' MAY O	9 1995	Jama a	NO. or CO.	11/1/2018										



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Approximate Interval Between **Onset and Death**

ompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit it, cremation, or removal.

event, the medical examiner must be notified at once. age 6 may be retained by the hospital or attending physician. MORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

BY FUNERAL DIRECTOR

BE COMPLETED

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BALTI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Thours after death. P	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examin
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7	P.	中本	ark
5	DING	Afte	E
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TEN	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ibe filed within 72 hours after death with the State Dept. of Heath and Memal Hygiene prior to burial, cremation, or removal.	88
>	RAT	RECT UITS &	E
	10	L Di	I Ite
	PITA	ERA in 7	1
	HOS	NEW MAN	TAN
	뿔	문	POR
	2	23	E

CERTIFICATION

MEDICAL

PHYSICIAN: Item 23

BY

COMPLETED

BE

2

that initiated events resulting in death) LAST

EXAMINER?

1 Natural

2 Accident

27. MANNER OF DEATH

1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL

29b. SIGNATURE AND TITLE OF CERTIFIER

5 Pending

Investigation

FOR STATE REGISTRAR		STATE OF N) / DEPAR					MENTAL	HYGIEN REG. NO.	_		
1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF				3. TIME OF DEATN
	Ch	arles Ho	well S	Sisler					Apri	1 2	8, 1	995	1:00 A
4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yra		IF UNDE		IF UNDER		7. DATE OF	BIRTN	, .	a. BIRTI	NPLACE (State or Foreign
212-14-795	51	1 🔀 M 2 🗆 F	78	YRS.	MONTHS	DAYS	HOURS	Arret.	JUNE	29,	1916	Count	ARYLAND
90. FACILITY NAME (If not int	stitution, give a	street and number)			9b. CIT	, TOWN	OR LOCATI	ON OF DE	ATN		9c. COL	INTY OF E	DEATN
REEDERS ME		L HOME					BOONS	SBOR	0			WAS	HINGTON
RESIDENCE OF DEC	10b. COUNT	_		40- 017	THE TOWNS	001004	71011						
inc. or i, form on cocarion												10d. INSIDE CITY LIMITS?	
MARYLAND WASHINGTON KEEDYSVIILE 100. STREET AND NUMBER 100. ZIP CODE 100. CITIZEN OF											1 YES 2 NO		
THE STATE OF THE PARTY OF THE P						10	i. ZIP COO				10g, CH		WHAT COUNTRY?
4327 TREGO	ROAD	I 12 WAS DECEDEN	T EVER IN II C	ADMED	1 40	WW 0 D T			756				S.A.
1 Never Merried 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)											14. RACE — American Indian, Black, White, etc. Specify:		
											Spec	WHITE	
	EDENT'S EDU		16a.	DECEDENT'S					16b. K	IND OF BUS	SINESS/IN	DUSTRY	WILLE
Elementary/Secondary (0		College (1-4 or 5 +	-)	(Give kind of life. Do NOT u	work done	auring me	ST OF WORKI	ng					
8			SE	LF-EME	PLOYE	D TI	RUCK	DRIV	ÆR.	J	TRANS	SPOR'I	TATION
17. FATHER'S NAME (First, Mi	iddle, Last)						16. MOT	NER'S NA	ME (First, Mic	ldle, Meiden	Surname)		
JOHN WILLIA	AM SIS	LER					MAG	GIE	MAE G	AYLOF	?		1.165011
190. INFORMANT'S NAME (7)	rpe/Print)			19b. MAILING	ADDRES	S (Street	and Numbe	r or Rural I	Route Number	City or Town	n, State, Zi	ip Code)	
SALLIE M. S	SISLEF	}		4327 '	TREG	O RO	AD, I	KEED	YSVILI	E, M	ARYL	AND	21756
20a. METHOD OF DISPOSITI	ON n 3 🗆 Rem	oval from State		CEAND DATE			ame of		DATE	20c. LO	CATION -	City or To	own, State
4 Donation 5 Other	(Specify)		SALE	M LUT	HERAI	V CE	METE	RY 5	/1/95	BAK	ERSV	ILLE	, MARYLAND
21. SIGNATURE OF FUNERAL	L SERVICE OF						ND ADDRE			7606	014	Nat	ional Pike
Toul	n.K	an	Paul M	I. Dear	n B	AST	FUNE	RAL I	HOME	Boon			
23. PART I. Enter the di	seesee, or	complications the	t coused the	death. Do	not enter	the mo	de of dy	ing, suc	h ee cardia				Approximate
shock, or he IMMEDIATE CAUSE (Fin	eart fallure.	List only one cau	se on each	line.									Interval Betwee
disease or condition	ei -		100		-								/
resulting in desth)		B. DUE TO	OR AS A CON	SEQUENCE O		_							1 week
		. 0		10									14
Sequentielly list condition of any, leading to immediate		DUE TO	OR AS A CON	SEQUENCE O									mone
cause, Enter UNDERLYII CAUSE (Disease or Injuri	NG	G	77										
ALOSE (DISSESS OF IUIT)	7	DUE TO	100 AC A CON	OFFICE OF	· ·								1

PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. COPD

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. DATE OF INJURY (Month, Day, Year)

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

26. PLACE OF DEATN (Check only one)

28d. DEŞCRIBE NOW INJURY OCCURED

rising Nome 5 - Residence 6 - Other (Specify)

29c. LICENSE NUMBER

D3

1 | YES 2 | NO

29d. DATE SIGNED (Month, Day, Year)

28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281, LOCATION (Street end Number or Rural Route Number, City or Town, State) a Could not be 4. Nomicide 29e. CERTIFIER

28b. TIME OF

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.

OTHER:

2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated.

26c. INJURY AT WORK?

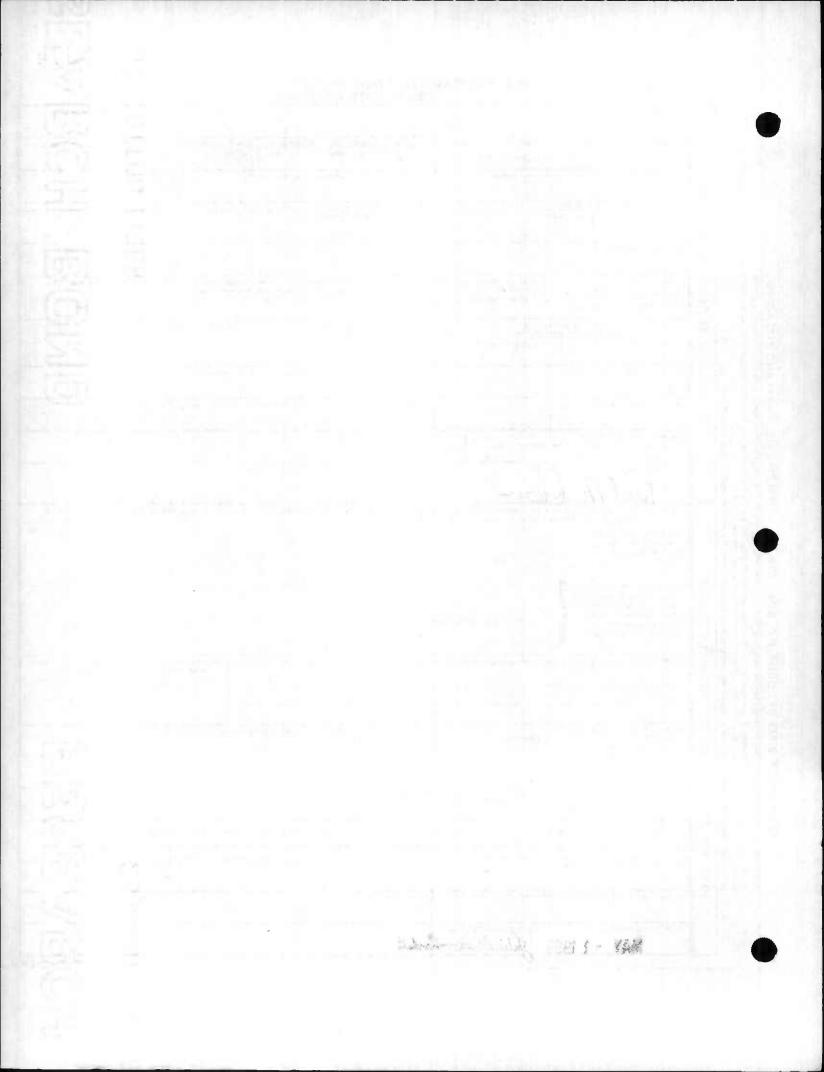
1 YES 2 NO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HOSPITAL:

100 Geeting Lane, Keedysville, Maryland 21756 301-432-2222 Dr. Robert Guedenet 31. DATE FILED (Month, Day, Year)





etained by the hospital or attending physician. should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

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1	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 5 may be re	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 be filed within 72 hours after death with the State Deot. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be no
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30. NAME AND ADDRESS OF PERSON WHILE

A, JONES

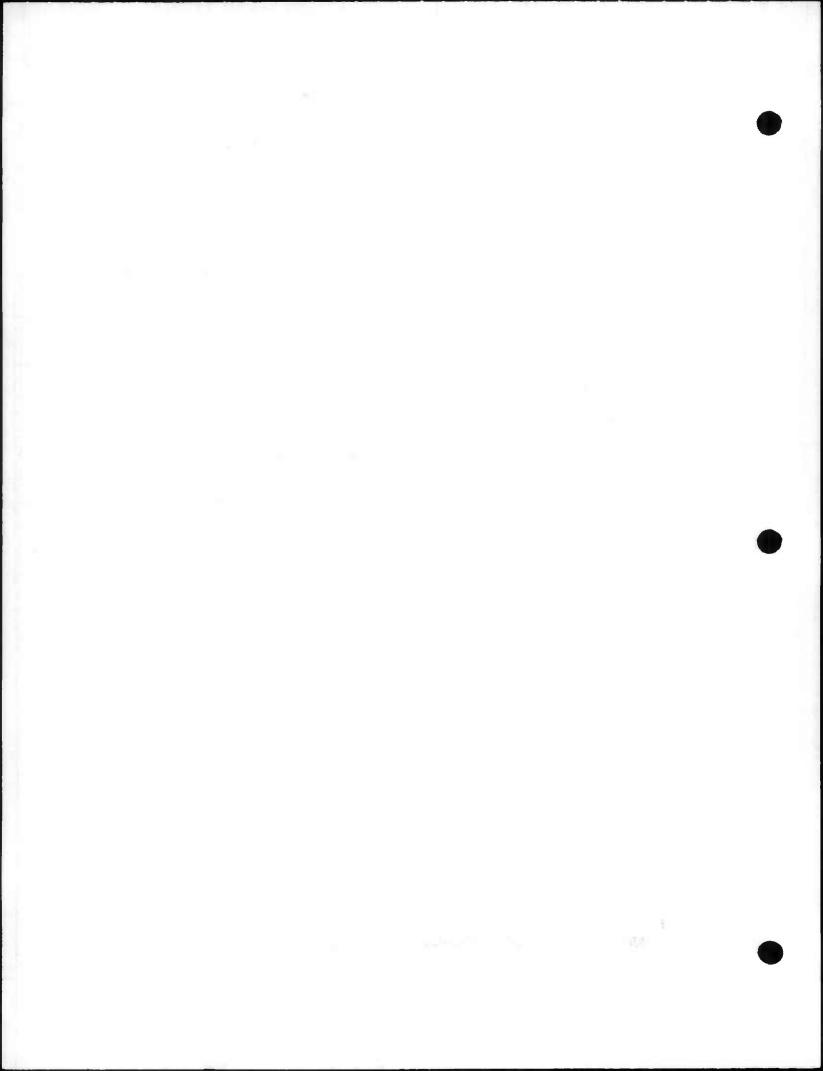
31. DATE FILED (Month, Day, Year)

MAY 0 2 1995

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
VES , MD 1198 KENLY,

												95	15575
	1 - FOR STATE REGISTRAR	STATE OF N	/MARYLAND /			T OF H			MENTAL	HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATN			3. TIME OF DEATN
	ROLAND OLIV	ER SNY	DER						Apri	1 30). 19	YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	hday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE						, 13		LACE (State or Foreign
	215-20-7511	1 M 2 - F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	Octob	per 29	192		Maryland
1	Sa. FACILITY NAME (If not institution, give	street and number)			9b. CIT	Y, TOWN O	R LOCATION	ON OF DE		201 23	_	NTY OF DE	
<u>۳</u>	19832 Bennie Dri	V/O			Ua	~~							
DIRECTOR	RESIDENCE OF DECEDENT	<u>ve</u>			пач	gerst	OWII				_ was	hing	con
H.	10a. STATE 10b. COUNT	•		10c. CIT	Y, TOWN	OR LOCATI	ON						10d. INSIDE CITY LIMITS?
	Maryland Was	hington		На	agers	stown							1 YES 2 W NO
Z Z	10e. STREET AND NUMBER			101. ZIP CODE							10g. CIT		HAT COUNTRY?
1 5	19832 Bennie Drive 21742										U.	S.A.	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF NISDAMIC ORIGINAL CONCENT OF NISDAMIC ORIGINAL CONCENT OF NISDAMIC ORIGINAL CONCENTS.												14. RACE	- American Indian,
IF YES, GIVE WAR OR DATES 1 ☐ YES 2 5→ NO Specify:													
													White
Ī	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KINO OF BUSINESS/INDUSTRY												
삗	Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Machinist												
§ \$	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist 16. NINO OF BUSINESS/INDUSTRY 16b. KINO OF BUSINESS/INDUSTRY 16b. KINO OF BUSINESS/INDUSTRY 16b. KINO OF BUSINESS/INDUSTRY 16b. KINO OF BUSINESS/INDUSTRY 16c. MICHORA OF BUSINESS/INDUSTRY 16c. MICHORA OF BUSINESS/INDUSTRY 16b. KINO OF BUSINESS/INDUSTRY 16c. MICHORA OF BUSI												
COM	17. FATHER'S NAME (First, Middle, Lest) Charles J. Snyder 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Elizabeth Crilley												
E H		lyder						zabe				Cril	ley
TO BE	19a. INFORMANT'S NAME (Type/Print)								Route Number	City or Town	, State, Zip	Code)	
	Irene F. Snyder			19832	Ber	nnie 1	Driv	е	Hager	stown	, Ma	rylar	nd 21742
	20a. METHOD OF DISPOSITION 1 N Burial 2 □ Cremation 3 □ Ram	oval from Stata	20b. PLACE / cemetery, cre	AND DATE	OF OISPO	SITION (Nam	ne of		DATE	20c. LO	CATION —	City or Tow	n, State
	4 Donation 8 Other (Specify)		Green]	Lawn	Mem.	Par				Will	iams	port.	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			- 1	NAME AND					1 11-		
) courses	N Solv	1//						ery F				own Md.
	23. PART L Enter the diseases or	complications that	t paused the de	ath. Do r	not ente	r the mod	e of dyl	ng, suc	h se cerdia	ic or respi	ratory an	est,	Approximata
	shock, or heart failure. IMMEDIATE CAUSE (Final	List only one cau	se on each line	P.									Interval Between
	disease or condition resulting in death)	· lonal	(OR AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECU	· lan	12	. 1	ille	ino					Human
	resulting in death)	DUE TO	OR AS A CONSE	OUENCE OF	F): /	710							1 years
		Moley	read n	10to	at a	Azr	and	ma	word.	1024	87 V	20280	£ 11
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUETO	(OR AS A CONSEC	DUENCE OF	F):		0-616				71	0-1-	
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	C									V'		
E	that initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
	reaulting in death) LAST	d											
	PART II. Other significant condition	ne contributing to	death but not -	o multima i	les Abres su			de cincile i	Direct La				
ার	San San San San San San San San San San	is continueding to	Gaath Dot Hot I	eaditing i	in the u	ilderlying	cause g	nven in	Part I. 2	4a. WAS AN		1	WAILABLE PRIOR TO
	11								1	YES 2	X NO		OMPLETION OF CAUSE OF DEATH?
: MEDICAL	DID TODA (GGO) 100 GGO)												YES 2 NO
N	DID TOBACCO USE CONT	RIBUTE TO CA				7	UNC	ERTAIN	4 D				
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	OTHE								
ΥS	1 TYES 2 NO	1 Inpatient 2 I			4 🗆 Nu	rsing Home		sidenca	8 Other (Specify)			
B	2 Accident Investigation				М	1 YE	S 2	NO					
9	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At ho atc. (Specify)	me, farm, s	Hreet, fac	tory, office			281. LOCAT City or	ION (Street a Town, State)	nd Number	or Rural Ro	ute Number,
							-						
APLE	(Check only one)												
Š	MEDICAL EXAMINE	R: On the basis of ax	camination and/or I	investigatio	n, In my	opinion, de	nth occur	ed at the	time, date ar	nd place, and	due to th	e cause(a)	and manner as stated.
ш	290. SIGNATURE AND TITLE OF CERTIFIE	R / /	7			T	29c. LICE	NSE NUN	ABER	1	29d. DAT	E SIGNED (Month, Day, Year)
OB	Tammure C	1.	ones	le	111	,	01	51	70	-	15	-2	- 95
12	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH OTER	27) (Time	Drint)	-	,	~ (-	

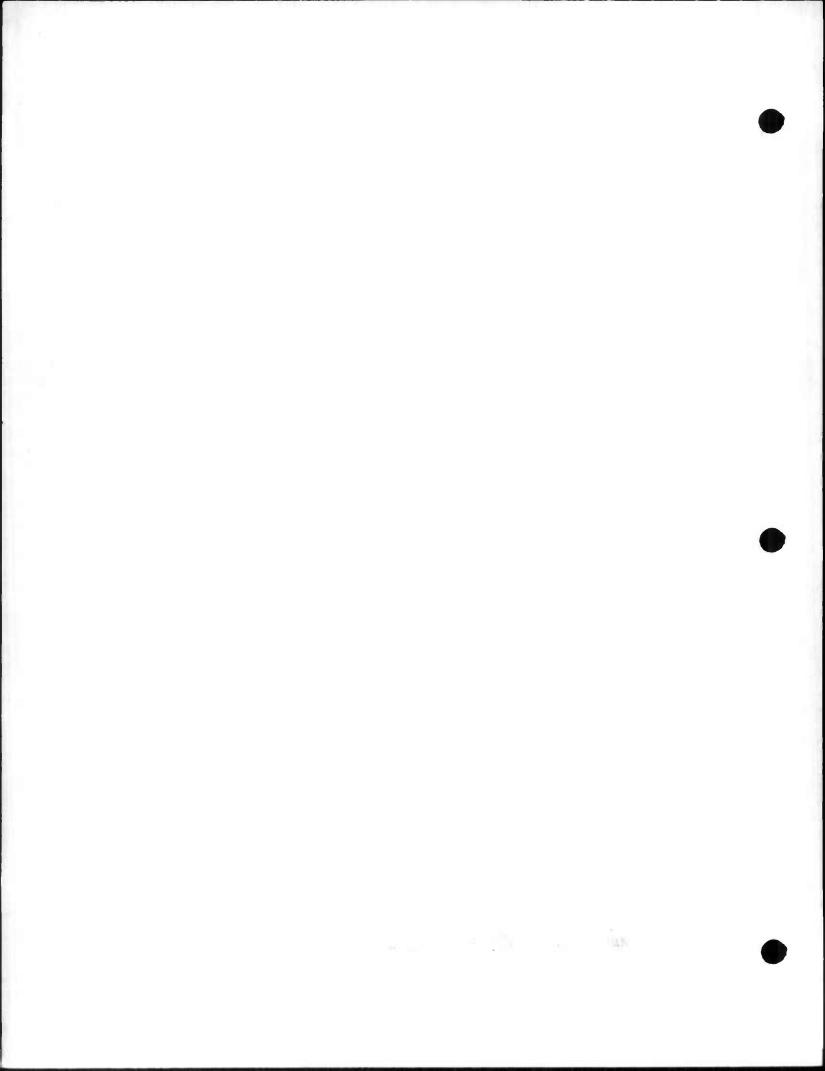
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HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	an Hamma Oran Later and American All and
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w	TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and comp be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cr	IMPODITANT: 19 form 20 in marked on form 22 about 12 in in 18 to the barrens and the barrens a

			STATE OF MARYLA				NTAL HYGIEN	E					
		REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.						
		1. DECEDENT'S NAME (First, Middle, Lest)	RIM	1511	5	11000°	DATE OF DEATH DA		3. TIME OF DEATH				
	- 1	4. SOCIAL SECURITY NUMBER 5	SEX / B.AGE (II	4-6-	21	1911	yay 3	199	0 1 0 1 10 1				
		222 27 2422	DM 2 F	yrs. last birthday)	MONTHS DAYS	# UNDER 24 HRS. 7.	Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
		9e. FACILITY NAME (If not institution, give street	- 1	/ This.				1	Maryland				
٥	2	Washington County			Hagerst	OR LOCATION OF DEATH	1	9c. COUNTY	1 4				
1 6	3	RESIDENCE OF DECEDENT			nagerbe			Wa	shouston				
DIBECTOR	Ź	10s. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?				
		Maryland Washing	yton	На	gerstown	n			1 N YES 2 NO				
4		10e. STREET AND NUMBER			10	r. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
"		727 Summitt Avenue				21740		U.S.	Α.				
Too. Street and Number 727 Summitt Avenue 106. ZIP CODE 109. CITIZEN OF WHAT COUNTY 107. ZIP CODE 109. CITIZEN OF WHAT COUNTY 108. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 109. CITIZEN OF WHAT COUNTY 110. NARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 109. CITIZEN OF WHAT COUNTY 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- 14. RACE — Amark Black, White, of Black, White, of													
2	Specify: White Spec												
E	Elementary/Secondary (0-12) College (1-4 or 5+) 12. Years Sales Manager Fourinment Company												
<u>ء</u>													
E L													
is in	1	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal	from State 20b.1	PLACE AND DATE (OF DISPOSITION (Na ther place)	ame of	DATE 20c. LO	CATION — City	or Town, State				
5	ı	4 Donation 6 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENS	SEE TIT	ttre ko	Se HIII	Cemetery5	5-95 C1	ear Sp	ring, Maryland				
examiner must be notified at once.	i		00.			las A. Fie		alHome					
	_	A Jaugla H.	There		1331 E	astern Blu	d North	Hager	stown Md				
шедіса		23. PART I. Enter the disesses, or companies, or heart failure. List	plications that saused on as	the death. Do r ch line.	not enter the mo	oda of dying, such as	a cardiac or reapi	ratory arrest	Approximate interval Between				
The T	1	iMMEDIATE CAUSE (Final disease or condition	Conclair			1/- +			Onset and Death				
		resulting in death) s	Cerebroc	asculo	v acc	ident			J Weeks				
traumatic event,	. 1		AUTENIOS	COLLIE TO	CAN	10 hannatatas	law di	CHAD	K. James				
y, or other traumatic CERTIFICATION		Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	Pi:	CORGOATCO	lar all	Leade	2 Xear				
S S		cause. Enter UNDERLYING							1 '				
TIFIC		CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF	ŋ:								
		reaulting in death) LAST							4				
5 -	. 11	PART II. Other significant conditions co	ontributing to death bu	t not resulting i	in the underlying	o cause given in Par	t I. 24a. WAS AN	ALTTOREY	24b. WERE AUTOPSY FINDINGS				
red, or item 23 shows any inj PHYSICIAN: MEDICAL		Poon Pori	planal 1	CHALLI	axin	W149.	PERFOR	MED?	MAILABLE PRIOR TO COMPLETION OF CAUSE				
ED N		multinl	To SIVin	VICEN	ching	~111	1 YES 2	NO.	OF DEATH?				
Shows		DID TOBACCO USE CONTRIBI	UTE TO CAUSE OF		S ENO D	UNCERTAIN [5		1 YES 2 NO				
NA I	1	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	1 OIACEKIMIA E							
SICI/			OSBITAL: Impetent I [] ER/Outpet	lient 3 🗆 DOA	OTHER:	ne 5 🗆 Residence 6 🗆	Other (Specific)						
HY S	1	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	285, TIM	E OF 26c. (NJ)		t. DESCRIBE HOW IN	JURY OCCUR	ID ID				
BY PH		1 Platural S Pending 2 Accident Investigation	Personal principle		The same of the sa	YES 2 NO							
	-	3 Suicide 8 Could not be 4 Hnmicide determined	38e. PLACE OF INJURY - building, etc. (Specif)	- At home, farm, a	treet, factory, office	e . 281	LOCATION (Street at City or River, State)	nd Number or A	lural Route Number.				
ETE ETE	Į,	Land American											
필		29a. CERTIFIER (Check only one)											
E COMPLETED		2 MEDICAL EXAMINER: O	n the basis of examination	and/or Investigation	n, in my opinion, d	leath occured at the time	, data and place, and	d due to the ca	use(a) and manner as stated.				
BE C		296. SIGNATURE AND THE OF CERTIFIER	Post. D	01		29c. LICENSE NUMBER	Fa	29d. DATE SIG	GRED (Month, Day, Year)				
P 0		Waber Mull	- 19 mol		lar	1043	54	· 51	4/95				
-		30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEAT	H (ITEM 27) (Type,	6/2	K	240	11.	+				
		Rubert Brull	MA	1.75.0	1 401	DIMAC A	100	rage	vslown				

Hagerstown



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mounts after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pag	Dept
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	1 - FOR STATE OF M.		RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIEN REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH SNYDER			2. DATE OF DEATH MONTH DATE MAY 1								
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 🖫 F	8. AGE (In yrs. lest birthdey 81 YRS.	# UNDER 1 YEAR # UNDER 24 HRS. MONTHS DAYS NOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-30-1	8. BIRTHPI ACE (State or Foreign							
8	90. FACILITY NAME (If not institution, give street end number) Williamsport Nursing	Home	96. CITY, TOWN OR LOCATION OF Williamspo	DEATH	%. COUNTY OF DEATH Washington							
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		ITY, TOWN OR LOCATION		10d INSIDE CITY							
	Maryland Washingto	n C	lear Spring		LIMITS? V 1 TES 2 NO							
ERAI	100. STREET AND NUMBER 14312 National Pike		101. ZIP CODE 21722		U.S.A.							
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT	EVER IN U.S. ARMED YES 2 YNO R OR DATES	13. WAS DECENDENT OF HISP If yee, specify Cuben, Mexi 1 YES 2 NO Spe	can, Puerto Rican, etc.)								
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind o	'S USUAL OCCUPATION of work done during most of working	18b. KIND OF BU	SINESS/INDUSTRY							
COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5+)		ol Teacher	Sch	ool							
CON	17. FATHER'S NAME (First, Middle, Last)	*		NAME (First, Middle, Maiden								
BE	Austin Herbert 190, INFORMANT'S NAME (Type/Print)	19h MAII e	NG ADDRESS (Street end Number or Run	zabeth Sp								
1 1	Linda Cushwa	100	2 National Pi									
net pe	20enMETHOD OF DISPOSITION 14 Journal 2 Cremetion 3 Removat from State	20b. PLACE OF DISP	osition (Neme of cemetery, crematory of 1 Cemetery		OCATION — City or Town, State							
H H	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LITERSEE	jot. Pau	22. NAME AND ADDRESS OF Thompson F	FACILITY	ear Spring, MD							
exam	log M. Odon		P.U. BUX 3	10 Clear	Spring, MD 21722							
medica	23. PART i. Enter the classes, or complications that shock, or haert fellure. List only one cause		o not anter the mode of dying, a	uch sa cerdiec or resp	iratory arrest, Approximate Interval Batween Onset and Daath							
ent, the	I resulting in deatiny	PARIETAL GI	LIOBLASTOMA		8 MONTHS							
matic ev	Sequentielly list conditions, if any, leading to immediate Due to (or as a consequence of):											
er trau	cause. Enter UNDERLYING CAUSE (Disease or injury	OR AS A CONSEQUENCE	OE:									
ry, or other traumatic CERTIFICATION	that initiated events reaulting in deeth) LAST	on as a consequence	OT).									
any inju	PART II. Other significent conditions contributing to	deeth but not reaultin	g in the underlying cause given		RMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE							
ME				-	1 YES 2 NO							
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		26. PLACE OF DEATH	Check only one)								
marked, or item 23 s BY PHYSICIAN:	1 YES 2 XNO 1 Inpetient 2 27. MANNER OF DEATH 28e. DATE OF (Month, December 1 Neutral 5 Pending		IME OF 28c. thJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURED							
≈ G	2 Accident Investigation 3 Suicide 28e. PLACE Of	FINJURY — At home, farm	M 1 YES 2 NO	281. LOCATION (Street City or Town, State	and Number or Rural Route Number,							
ANT: If Item 2 COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of experience of											
MPORTANT: If Item D BE COMPLE	29b. SIGNATURE OF CERTIFIER		29c. LICENSE I	IUMBER	29d. DATE SIGNED (Month, Day, Year) MAY 11, 1995							
₹ 2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS		•									
	TED E. HOWE, M.D., 154 N 31. DATE FILED (Month, Day, Year) MAY 1 2 1995 Julia Dawelese		AN STREET, WILLI	AMSPORT, MI	0 21795							
	MAY 1 2 1995 Julia Dawelese	tordall										

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Approximata interval Between Onset and Death 2 WEEKS

MD

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FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOA 13149,	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be
\in	8
	OSPITAL

		1. OECEDENT'S NAME (First, Middle, Last)		2. DATE	2. DATE OF DEATH DAY YEAR 3. TIME OF DEA											
		VIOLA SUSIE SHE	ARER							MAY	14,	1995		4:50 A		
		4. SOCIAL SECURITY NUMBER	5. SEX	11 5 7 5	In yrs. last birthday	IF UNDER	1 YEAR	HOURS	MIN.	(Month	OF BIRTH , Day, Year)	- 1	B. BIFTH Country	PLACE (State or Foreign y)		
D		220-16-2470	1 M 2 X F	8	35 YRS.									RYLAND		
3 should	~	9e. FACILITY NAME (If not institution, give st						OR LOCAT				9c. COUN				
2,	힏	WILLIAMSPORT NU	JRSING	HOME		WILLIAMSPORT					WASHINGTON					
es 1	DIRECTOR	10e. STATE 10b. COUNTY	1		10c. CI	TY, TOWN	OR LOCAT	TION					П	10d. INSIDE CITY		
physician. burial-transit permit. Pages 1, 2,	DIR	MARYLAND WAS	SHINGTO	N		AGE	RSTO	NWG						LIMITS?		
E	AL	10e. STREET AND NUMBER					101	. ZIP COD	_			1.5		VHAT COUNTRY?		
in. ansit	FUNERAL	301 WAKEFIELD F				21740 U.S							S.A	١.		
nysicia urial-tu	E	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDEN	YES	2 X NO	I U.S. ARMED 13. WAS DECENDENT OF HISPA 15. WAS DECENDENT OF HISPA 16. Yes, specify Cuben, Mexic						PANIC ORIGIN? (Specify Yee or No— 14. RACE Black, rican, Puerto Ricen, etc.)				
	B	3 X Widowed 4 Olvorced	IF YES, GIVE Y	MAR OR D	ATES		1 🗍 YES	2 □XNO	Specif	y:			Speci	" WHITE		
iftend e as	8	15. DECEDENT'S EDUC (Specify only highest grade	CATION			18e. DECEDENT'S USUAL OCCUPATION					. KIND OF BUS	INESS/INDI	USTRY			
or a for us	區	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Iffe. Do NOT	(Give kind of work done during most of working life. Do NOT use retired.)										
ospita thed	鱼	6			HOME	MAKE	R				OWN	HOME				
detac onc	COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAME (First, Middle,						,				
d by	BE	VERNON ELLSWO	JRTH W	OLFE				ID		REBE		KLIN				
o retained by the hospital or attending 5 should be detached for use as the notified at once.	5	19e. INFORMANT'S NAME (Type/Print)	VCI								ber, City or Town			D 04740		
y be nage 5	-	REGAN H.L. SHA	4W						_	IVE,				ID. 21742		
ector, p		20e, METHOO OF DISPOSITION 1 A Feriel 2 Cremetion 3 Rem	oval from State	D C	other place)	SITION (N	me of ce	metery, cre	matory or V ∩¹	5_17_	20c. LO	CATION - C	TOLIN	wn, State , MARYLAND		
direc direc		4 Donation 6 Other (Specify)	CENSEE	_ n t	IST HAV											
death. Pag funeral dir examiner		104.	Real	1		17	NDRI	EW K	CO	FFMAN	FUNEF	RAL H	OME,	INC.		
the fu		K. Noll	TSEAL	ig	-	_								,MD. 21740		
nted within-wurs after death. Page 6 may be completely filled in by the funeral director, page rial, cremation, or removal. c event, the medical examiner must be it.		23. PART I. Enter the disasses, or cahock, or heart failure.				not anta	tha mo	oda of dy	ring, auc	ch ss card	diac or respi	ratory arm	est,	Approximata interval Between		
withir correct pletely filled is cremation, or rent, the me		iMMEDIATE CAUSE (Final disease or condition												Onset and Deat		
ompletely il, cremati event, t		reaulting in death) a. SEPSIS Due to (or as a consequence of):												2 WEEKS		
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execute n and c to buria	CERTIFICATION	Sequentially list conditions, if any, leading to immediate														
siciar prior trau	SAI	cause. Enter UNDERLYING	c.													
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th cereding Hyg	ᇤ	reaulting in desth) LAST	d													
the dear of Menta of Menta injury,		PART ii. Other aignificant condition	na contributing to	o death b	out not resulting	g in the u	ndariyin	g cause	given in	Part i.	24a. WAS AN	AUTOPSY	246	. WERE AUTOPSY FINDINGS		
that the ed by the th and any in	MEDICAL	ALZHEIMER'S D									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
signer signer Health			TOLINOL								1 🗌 YES 2	_1Mao		OF DEATH? 1 YES 2 NO		
w requires been sign pt. of Healt 3 shows				_						_						
has the Dept	A	25. WAS CASE REFERRED TO MEDICAL	-				26. P	LACE OF	DEATH (C	heck only o	ne)					
AN: The ficate h State (Sic	EXAMINER? 1 ☐ YES 2 ☐ŽNO	HOSPITAL: 1 Inpetient 2	☐ ER/Out	petient 3 🗆 DOA	OTHE 4 X Nu		ne 5 🗆 f	Reeldence	8 🗆 Othe	r (Specify)					
YSICIA s certif th the od, or	PHYSICIAN:	27. MANNER OF DEATH	28e. DATE O	F INJURY Day, Year)		IME OF NJURY		JURY AT		28d. DE	SCRIBE HOW I	NJURY OCC	CURED			
NG PHYS fter this eath with marked	ВУ	1 Natural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			М		YES 2	□ NO							
R: Aft er des		3 Suicide 8 Could not be	28e. PLACE building	OF INJURY	Y — At home, farm	, street, fa	tory, offi	ce			or Town, State)		or Rural	Poute Number,		
ATTE ECTO In 28	ETE	4 Homicide determined														
L DIRECT Pours	밀	29a. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the best of	of my know	wiedge, death occi	irred at the	time, dat	e end plac	e, end du	e to the ca	use(e) end mai	nner as stat	ed.			
HOSPITAL FUNERAL WITHIN 72 P	COMPLET	one) 2 MEDICAL EXAMINI	ER: On the basie of	examinatio	on end/or investige	tion, in my	opinion,	death occ	ured at the	e time, date	end place, en	nd due to th	e cause(e) and manner ee stated.		
THE HOSPI TO THE FUNEP TO FILED WITHIN	ш	296. SIGNATURE AND TITLE OF CERTIFIE	4.4	0				29c. LI	CENSE NU	IMBER		29d. DAT	E SIGNE	(Month, Day, Year)		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completel be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event,	0 8	< THOWE,	M	<u> </u>				D	337	00		M	AY I	14, 1995		
	LES	30 NAME AND ANDRESS OF PERSON WE	O COMPLETED CAL	USE OF O	EATH ATEM 27) /S	no Delne)										

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TED E.

HOWE,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

NORTH ARTIZAN STREET, WILLIAMSPORT,

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPARTM	MENT OF H	EALTH AND	MENTAL HYGI				
	1. DECEDENT'S NAME (First, M	iddle, Last)			A12 01	DEATH	2. DATE OF DEATH		3	. TIME OF DEAT	Н
	HARVEY	JAMES			STI	JE.	MAY 8.	1995	YEAR	8:30 A	
	4. SOCIAL SECURITY NUMBER 212-14-5992		6. AGE (In yrs. In:		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Pay, Year April 2				
	8e. FACILITY NAME (If not institu	ution, give street and number)		96	. CITY, TOWN O	R LOCATION OF D			TY OF DEA		
TOR	16183 COBB	ISLAND ROA	D		COBB	SLAND		СН	ARLE	S	
DIRECTOR	MD 10a. STATE	Charles			own or located by Isl					Dd. INSIDE CITY	
	100. STREET AND NUMBER 16183 Cobb	Island Rd.			101	20625				AT COUNTRY?	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Maries 3 Widowed 4 Divorce	12. WAS DECEDEN FORCES? 1	YES 2	RMED NO	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify an, Puerlo Rican, etc.) fy:	Yes or No-	14. RACE -	American India White, etc.	
COMPLETED	15. DECEDI (Specify only hi Elementary/Secondary (0-12	ENT'S EDUCATION ghest grade completed)) College (1-4 or 5-	(G	ilve kind of work . Do NOT use re	•	PN st of working	16b. KIND OF	BUSINESS/INDI		-	
₹ I			Wa	aterma	111				food	1	
BE CO	17. FATHER'S NAME (Flist, Middl Benjamin St					Mari	a Stine				
10	Ann Stine	(Print)	19 Ge	eneral	oness (Street e	nd Number or Aural Very C	Obb Isla	Town, State, Zip	Code) 2 (0625	
	20a METHOD OF DISPOSITION 1 Burlel 2 Cremellon 4 Donation 5 Other (Sp	3 Removal from State	20b. PLACE	AND DATE OF D	IPCh C		OATE 200.	Ways		•	
	21. SIGNATURE OF FUNERAL S										
	> Stavil	C. Echol	M0094		P.O.	Box 56	Ö LS FUN 7 LaPlat	a,MD	206		
	23. PART I. Enter the dise shock, or hear IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	esea, or complications that feliure. List only one cau	t caused the dese on each line	mest	anter tha mo	de of dylng, suc	ch as cerdisc or re	spiratory srre	est,	Approxima Interval Ba Onset and	tween
CERTIFICATION	Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated svents resulting in death) LAST	c	(OR AS A CONSE		Hea	ut D	me				
AL CE	PART II. Other algoliticent	d. conditions contributing to	deeth but not i	esulting in ti	he undariving	cause given in	Part I 24a WAS	AN ALITOPSY	245 W	ERE AUTOPSY FIR	MOUNCE
MEDICA	Ca Pulm	turber Park	my Day	4	Hyps	usplues	PER	FORMED?	CC	MILABLE PRIOR 1 OMPLETION OF C F DEATH?	AUSE
PHYSICIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO M	CONTRIBUTE TO CA				UNCERTAI	ИП				
5	EXAMINER?	HOSPITAL:			THER:						-
2	1 YES 2 NO	1 Inpetient 2 I		28b. TIME OF			6 Other (Specify) 28d. DESCRIBE HO				
BY P	1 Natural 5 Per	(Month, D	ay, Ybar)	INJURY	WO		200. DESCRIBE HO	W INJURY OCC	OHED		
		ermined 28e. PLACE O building,	F INJURY — At ho etc. (Specify)	ine, ferm, stree	t, factory, office		28f. LOCATION (Str. City or Town, St		or Rural Rout	e Number,	
COMPLEI		ING PHYSICIAN: To the best of L EXAMINER: On the basic of ea								nd manner ee st	ated.
E C	29b. SIGNATURE AND TITLE OF		44			29c. LICENSE NU	MBER			onth, Day, Year)	
2	30. NAME AND ADDRESS OF PE	ERSON WHO COMPLETED CALL	E OF DEATH (TT	M 27) /5 0:	of)	D-010	09)-9-0	15	
	HENRY L. BU	RKE MD 115-	-A LAGR	RANGE	,	E_P.O.	BOX 591	LAPL	ATA	MD. 2	0646
	MAY 0	r) 32. REGISTRA	R'S SIGNATURE	Cardalle							

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DIVISION OF VITAL RECORDS, P.O. BOX

		FOR STATE REGISTRAR	STATE OF MARY				F HEALTH AND OF DEATH	MENTAL	HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE (OF DEATH		EAR 3.	TIME OF DEATH	_
		CLARA MAY	SHRYOCK					MA		1995	EAR	2:20AM	М
PI		4. SOCIAL SECURITY NUMBER 219-01-2046	10 FEMATE	(In yrs. lest	YRS.		YS HOURS MIN.	Dec	Dey, Year)		Country)	ACE (State or Foreign	n
2, 3 should	стов	9a. FACILITY NAME (If not institution, give : CTTTZENS NITESTING RESIDENCE OF DECEMENT	,				WN OR LOCATION OF D DERICK	EATH		9c. COUNTY FRED			
Pages 1,	DIREC	10 a. STATE 10b. COUNT	Y EDERICK			DSBORC					10	d. INSIDE CITY	
sit permit.	ERAL (100. STREET AND NUMBER 11727 OAK HILL RI),			**	101. ZIP CODE 217	 98		10g. CITIZER		T COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 NO		If yes	DECENDENT OF HISPA s, specify Cuben, Maxico YES 2 NO Specifi	en, Puerto R	(Specify Yelican, etc.)	a or No — 14	RACE -	Americen Indian, Thite, etc.	
	ED	3 Widowed V1 OWOC 15. DECEDENT'S EDU (Specify only highest grade	NO (CATION completed)	(Giv	e kind of v	USUAL OCCUI	NO PATION g most of working	16b.	KIND OF BU	SINESS/INDUS	WHI	TE	_
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)		DO NOT US $FM\Delta K$					HOME			
3 6 5 Z		17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA						
MAR retained to 5 should notified	BE (CLARENCE SMTTH 19a. INFORMANT'S NAME (Type/Print)		19b.	MAILINO	ADORESS (Str	meet and Number or Rural			F POOL Vn. State, Zip Co		_	
(D) (E)	5	CLEO S DERRY	1 20			OAK HT		OODSB		OATION OF	MD	21798	
AORE le 6 may rector, pag		1 Buriel 2 Cremation 3 Buriel 4 Donation 5 Other (Specify)		metery, crem	atory or of			5/7		OODSBO			
BALTIMORE, after death. Page 6 may b ty the funeral director, page moval.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	an	/		WOODS		D. D.	HARTZI			
de to at		23. PART L Enter the diseases, or ahock, or heart fallure.	complications that cause List only one cause on	d the dee	th. Do n	ot enter the				iratory arrest	,	Approximata intervsi Between	
ety fille nation,		IMMEDIATE CAUSE (Final	a. Complete out to long as			reat	failure					Onset and De	
P 5 5 - 6	Z		/ /			1/0)						5411	1
OX O Sician Orior t	CERTIFICATION	Sequentially liet conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c. Valvu	la	Ly	ort.	diseasi	(unk	
P.O. h certification of the ce	CERTIF	that initiated events reaulting in death) LAST	d	A CONSECU	JENCE OF):							
이 을 표를 들	4	PART II. Other algnificent condition	Alzhu	but not re	aulting i	1	,	Part I.	24e. WAS AN PERFOI		AV	RE AUTOPSY FINDIN	
RECOR w requires that been signed by or. of Health an shows any	MEDIC	PNUmmia) 18-ca		_	1 TYES	NO	Of	MPLETION DF CAUS OEATH? YES 2 NO	iE
AL F ne law has be Dept. n 23 s	IAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE (H (Check only		Ν□		_	L		
VITA	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out	Ipatient 3	DOA	OTHER:	Home 5 - Residence	8 Other	(Specify)	-			
PHYSIC CE THIS CE WITH I WITH I	BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)		28b. TIMI INJ	URY	NJURY AT WORK?	28d. DE\$6	CRIBE HOW	INJURY OCCUR	ED		
DIVISION DR ATTENDING I DIRECTOR: After hours after death item 28 is mai		3 Suicide 8 Could not be determined	28e. PLACE OF INJUR building, atc. (Spe	Y — At hom	e, farm, s	treel, lactory,	office	281. LOCA City o	TION (Street Town, Stete)	and Number or i	Rural Rout	e Number,	
DIV SPITAL DR A NERAL DIREC THIN 72 hours NT: 11 item	COMPLETED		ICIAN: To the beat of my known.								puse(s) er	ed manner aa stated	d.
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	I he				29c. LICENSE NU	-		29d. DATE SI	1-1	onth, Day, Year)	
	F	Gene F. Ashe					Center	Wood	sboro	,MD 21	798		
		MAY U 8 1995	32. REGISTRAR'S SIG	NATURE W Road	all								
												DHMH-18 Re	ev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death carificate be executed within the form after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this carificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should IMPORTANT: It liem 28 is marked, or liem 23 shows any injury, or other traumatic avent.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	i	1. DECEDENT'S NAME (First, Middle,	Last)			1.		2. DATE OF DE		3. TIME OF DEATH
		RUTH YOUNG S	CHRIER			Sch	RIER	APRIL	28	995 1145 AM
	1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR	TH	a. BIRTHPLACE (State or Foreign
		215-20-0626	1 □ M 2 🂢 F	69	YRS. MON	THS DAYS	HOURS MIN.	4-16-1	926	Va.
١.	_	9a. FACILITY NAME (If not institution,	-			CITY, TOWN	OR LOCATION OF D	EATH	9c. COU	NTY OF DEATH
activation	5	PENINSULA REGI		AL CENTE	ER	SA	LISBURY			WICOMICO
1 8	3	RESIDENCE OF DECEDEN 10e, STATE 10b, C	DUNTY		10c CITY TO	WN OR LOCAT	TION			10d. INSIDE CITY
2		Md. W	icomico			sbury	TION .			LIMITS?
		10e. STREET AND NUMBER	<u> </u>		Dail		. ZIP CODE		100 CIT	1 YES 2 NO
0		8291 Arden D	rive			"	21801		USA	
BY EINEDAL	5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	RMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Sne		14. RACE — American Indian.
L L		1 Never Married 2 Married	FORCES? 1	YES 2 2	NO	If yes, sp	ecity Cuban, Mexico	en, Puerto Ricen, e	etc.)	Black, White, etc.
		3 Wildowed 4 Divorced						,		White
COMPLETED		15. DECEDENT'S (Specify only highest	grade completed)	(0	ECEOENT'S USUA	done during mo		16b. KIND	OF BUSINESS/INI	DUSTRY
<u>u</u>	ן נ	Elementary/Secondary (0-12)	College (1-4 or 5 d	·)	a. Do NOT use reti	,	1	Wice	omico Co	ounty School
g 2		11		Ed	ucation	nal Ale				
		17. FATHER'S NAME (First, Middle, Law Jessie Little	*					ME (First, Middle,		
B A	4	19e. INFORMANT'S NAME (Type/Print)		- 4		7500 (0)	nd Number or Rural	Burrows	0	
TO RE COM	2	Louis B. Schr		,			Drive, S			
2		20a, METHOD OF DISPOSITION		20h PLACE	AND DATE OF DIS				, ,	City or Town, State
200		1 N Burlel 2 Cremation 3 4 Donation 5 Other (Specify)		cemetery, cr	Stephen	lace)			Delmar,	
5		21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE	1 56.	o cepiteli	22. NAME AN	O ADDRESS OF FA	CILITY		De.
Y A		D. 11 . 11	1 1/4	/			t Funera			
_	\dashv	23. PART I. Entar the diseases	Brown !	_		13 E	. Grove	St. Del	mar, De	19940
	ŀ	shock, or haart fal	iure. List only ona cau	se on aach iin	Beth. Do not e	ntar tna mo	de of dying, suc	n an cardiac o	reapiratory an	reat, Approximata interval Batween
	1	iMMEDIATE CAUSE (Final disease or condition	1.1830	emia						Onset and Dasth
		resulting in death)	8.	(OR AS A CONSE	OURNES OR:					2 19425
	.		_ (0	nebul	Tala	-Q				7.10
CERTIFICATION		Sequentially list conditions, if any, leading to immediate	b. OUE TO	(OR AS A CONSE	QUENCE OF	100				76/9
S S		csuse. Enter UNDERLYING	. (arkis	usni	atter				TICLAIZ
		CAUSE (Disesse or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE OFT					1 1
H		resulting in deeth) LAST	d				1			
		PART II. Other significant cond	ditions contributing to	deeth but not	resulting in the	e underiving	ceuse given in	Part i 24a V	WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL						,,	g	P	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
								_ '0'	VES 2 TYMO	DF DEATH?
2	. 11	DID TOBACCO USE CO	NTRIBUTE TO CA	LISE OF DE	TH YES F	J NO E	INCEDTAN			1 WES 2 NO
PHYSICIAN:		25. WAS CASE REFERRED TO MEDIC			CE OF OEATH (C)		OITCERIAII	4 L		
SIC		EXAMINER?	HOSPITAL:		ОТ	HER:	e 5 🗆 Residence	a Cohen (Cons	4.1	
; `		27. MAYINER OF DEATH	28s, DATE OF	INJURY	28b. TIME OF	28c. INJ	URY AT		HOW INJURY OC	CURED
BY P		1 Netural 5 Pending 2 Accident Investiga	(Month, Di	ay, 19ar)	INJURY	M 1 1	RK? /ES 2 NO			
		3 Suicide 8 Could no	28s. PLACE OF	F INJURY — At he atc. (Specify)	oma, farm, street,	factory, office				or Rural Route Number,
TED		4 Homicide determin	ed Summy.	are (opeony)				City or Town	, State)	
COMPLET		29e. CERTIFIER Check only	PHYSICIAN: To the best of	my knowledge, de	with occurred at 1	the time, date	and place, and due	to the cause(a) e	nd manner as sta	led.
MO										ne cause(s) and manner as stated.
		296. SIGNATURE, AND TITLE OF CER					29c. LICENSE NUI			E SIGNED (Month, (Day, Year)
BE		Cuxxx T	Tan an.				17	625	D 2	+12800
<u></u> 2	1 Ulin	30. NAME AND ADDRESS OF PERSO	N WHO COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type, Print)	- 0		0		1-000
				- 5	51 0	110	1 1	O e Y 1	6. 4	
		TAN, COPSTA	STU	347-D	River	YOU	V1.	2000	DWI	MI
		31. DATE FILED (Month, Day, Year)	NTE 32 REGISTRA	R'S, SIGNATURE		7000	VI.	2000	DW	PUP
		31. DATE FILED (Month, Day, Your) MAY U1 19!	NTE 32 REGISTRA	2K7 - D R'S, SIGNATURE UKLOC NON		YOU	VI.	2000	Dw	PW

and and a second

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 1995 SIMS CYNTHIA 18, 11:58 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year Dec. 28, IF UNDER 1 YEAR IF UNDER 24 HRS. 8, BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 154-64-5182 32 1 M 2 X F YRS. 1962 New Jersey Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia Chesapeake permit. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit intal Hyglene prior to bunal, cremation, or removal. 313 Begonia Lane 23325 U.S.A. hours after death, Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 1 Never Married 2 X Married BY 1 TES 2XX NO Specify Specify: Black 3 Widowed 4 Divorced ETED 15. DECEDENT'S EOUCATION 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Student Troy State University 5+ notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Isaac C. Durant Annie C. Williams 띪 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Gregory L. Sims 313 Begonia Lane Chesapeake, Virginia 23325 pe 20a. METHOD OF DISPOSITION
1 Burisl 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cometery, cremetory or other piece)

Evergreen Cemetery 4/24/95 Newark. reen Lemetery
22. NAME AND ADDRESS OF FACILITY
1822 Portsmouth
Portsmouth, VA New Jersey examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blvd. 23704 Course: medical 23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween **IMMEDIATE CAUSE (Final Onset and Death** the disease or condition_ DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other signed by the attending ph Health and Mental Hyglene DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST any injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAJI ARI F PRIOR TO COMPLETION OF CAUSE YES 2 NO EVES 2 | NO this certificate has been with the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: XXYES 2 NO 1 Inpatient 2XXR/Outpatient 3 DOA 8 Other (Specify) 0 27. MANNER OF DEATH DATE OF BUILDING 28b. TIME OF 26c. INJURY AT WORK? is marked, ☐ Natural 00 м DIRECTOR: After the hours after death vitem 28 is mark 1 YES ВУ 80 Investigation 2 Accident PLACE OF INJURY - At hon Sulcide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER TO THE HOSPITAL DI TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If Its 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) (Check only 2 X YEDICAL EXAMINER besis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. INE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) APRIL 0 O.C.M.E 19. 1995 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) (BC

31. DATE FILED (Month, Day, Year)

02

1995

32. DEGISTRAR'S SIGNATURE

Penn Street, Baltimore, Maryland 21201

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARY				EALTH AND DEATH	MENTA		E	•	
	1. DECEDENT'S NAME (First, Middle, Lest) JOHN	HUBER	T TAY	LOR	2	DEATH	2. DATE MONT	REG. NO.	199	YEAR	3. TIME OF DEATH - 1/200 A M
		1x M 2 □ F 7	(In yrs. last birthda	MONTHS	DAYE	IF UNDER 24 HRS. HOURS MIN.	9 – 1	of BIRTH th, Day, Year) 14-71		WAS	SH.D.C.
DIRECTOR	5306 N. ENGLEWOOT					VILLE	EATH		_	OF DE	GEORGES
	MD PRINCE 100. STREET AND NUMBER	ES GEORGE		HYAT	TSV	LLE					10d. INSIDE CITY LIMITS? 1X YES 2 NO
BY FUNERAL	3 Wildowed MY Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO Specify: Specify:									A . — American Indian, White, etc.	
COMPLETED		TION mpleted) College (1-4 or 5+)	18e. DECEDENT (Give kind life. Do NOT	of work done Tuse retired.)	during mo.	N st of working		GOVERI			BLACK
BE COM	17. FATHER'S NAME (First, Middle, Last) ANDREW E. TAYLO	1	HOUR	DIND	IS IX	18. MOTHER'S NA		MIddle, Meiden			
10	19e. INFORMANT'S NAME (TyperPrint)	20	530	6 No	rth SITION/Na		pood	DR. H		svil	
	AlABurisi 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) HARMONY MEMORIAL PARK Landover MD 21. SIGNATURE OF EUNERAL SERVICE LICENSEE WENT OF EUNERAL HOME 3821 14th ST.N.W.										
	23. PART I. Enter the diseases, or con ahock, or heert feliure. Lis IMMEDIATE CAUSE (Finel disease or condition resulting in death)	nplicetions that couse on tonly one couse on META STAT	each ilne.	o not enter	the mo	de of dyling, aud	ch aa cen	diec or reapi			Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		A CONSEQUENCE								
PHYSICIAN: MEDICAL O	DEHYDRATION, U		but not resultin	g in the ur	nderiying	cause given in	Part I.	24a. WAS AN PERFOR	MED?	10	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN: N	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH		only one)	UNCERTAI	N 🔲				7 100
		OSPITAL: Inpatient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	28b. T	OTHEI 4 Nur	28c. INJU WO	RK?		M (Specify)	JURY OCC	URED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Sp	Y — At home, ferm	n, street, fact		ES 2 NO		CATION (Street e. or Town, State)	nd Number	or Rural Ac	oute Number,
COMPLETED		N: To the best of my kno									and menner ee stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER GENERAL MO (DME)	OMO STED CALLOS OF D				29c. LICENSE NUI	Z S	5	≥ M	SIGNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO C J. BERGER W # 205 31. DATE FILED (Month, Day, Year)	7720 1	NISCON!		re	Bei	Tus	da	Ma	28	0874
	MAY 03 1995 Juli	37. REGISTRAR'S BIG	Tall								

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

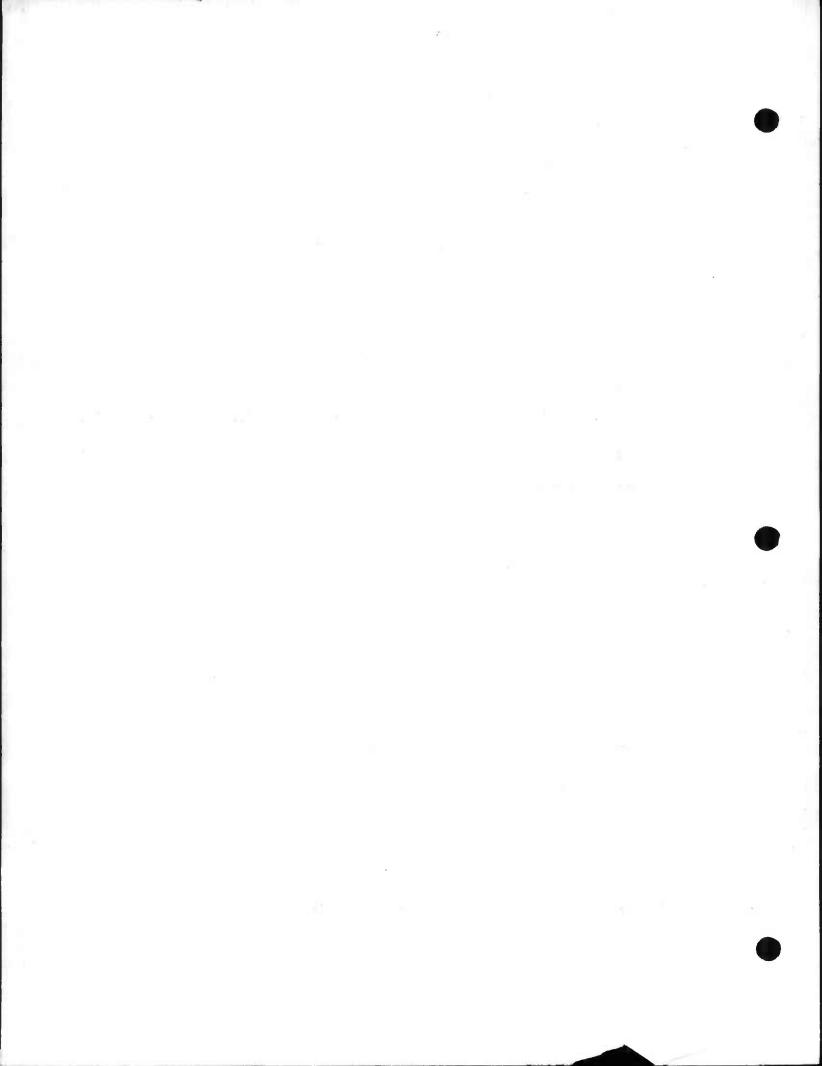
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	4 0000000000000000000000000000000000000								7	HEG. NO.		-	
	1. DECEDENT'S NAME (First	1,00								DATE OF DEATH	Y	YEAR	3. TIME OF OEATH
			nia Cre	ighton	Thom	as				May 8, 1	995		8:00 P M
	4. SOCIAL SECURITY NUME		5. \$EX	6. AGE (In yrs. la	st birthday)	IF UNDER 1		IF UNDER 24 HRS	7. 1	DATE OF BIRTH			LACE (State or Foreign
	220-26-11	35	1 🗌 M 2 💢 🌾	94	YRS.	MONTHS	DAYS	HOURS MIN.	l b	Month, Day, Year) ec 28,19	വ	Mar	yland
	90. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CITY. T	OWN OR	LOCATION OF		20,17		INTY OF OE	
Œ	Mallard Ba	v Mure	ing Home										
DIRECTOR	RESIDENCE OF DEC	CEDENT	THE HOME				Jamb	ridge				Dorch	ester
Ä	10a. STATE	10b. COUNT	Y		10c. CIT	r, TOWN OR	LOCATIO	N					10d. INSIDE CITY
	Maryland	Do	rchester		F	ishing	2 Cr	eek					LIMITS?
	10e. STREET AND NUMBER							IP CODE			10a CIT		AT COUNTRY?
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BE	Benjamin .		Creight	on				Luc	у C:	reighton			
10 E	19a. INFORMANT'S NAME (7	Type/Print)		.19	b. MAILING	ADDRESS (S	Street and	Number or Rur	al Route	Number, City or Town	, State, Zip	p Code)	THE STATE OF
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHYSICIAN: MEDICAL

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31. DATE FILED (Month, Day,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Boatric 6:19 TUPIN apr. 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) SEPT 18, IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 X F DAYS HOURS 080-16-3519 YRS. 74 1920 NEW YORK 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND HOWARD COLUMBIA 1 YES 2 XXNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 8997 WATCHLIGHT COURT 21045-4228 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuber
1 ☐ YES 2 🔀 NO BY 3 Widowed 4 Divorced Specify: Specify: WHITE 16e. DECEDENT'S USUAL OCCUPATION
TOkus kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 2 BOOKKEEPER RESIDENTIAL CONSTRUCTION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) **ABRAHAM** DAVID TRUPIN BE ANNIE WEINER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 DAVID WASSERMAN 6167 ANCHOR LANE, ROCKLEDGE, FLORIDA 20s, METHOD OF DISPOSITION
1 (A Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State MT. LEBANON CEMETERY 4 Donation 5 Other (Specify) 5/2 ADELPHI, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one ceuse on each line. interval Betwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition auterioschevotre resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Setes mellitus 1 - YES 2 X NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) YES 2 NO HOSPITAL: OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1/ Natural 5 Pending 1 YES 2 NO 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 6 Could not be 4 Homicide 29a. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end manner as attated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

412m210 8158

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22. REGISTRAG'S SIGNATURE

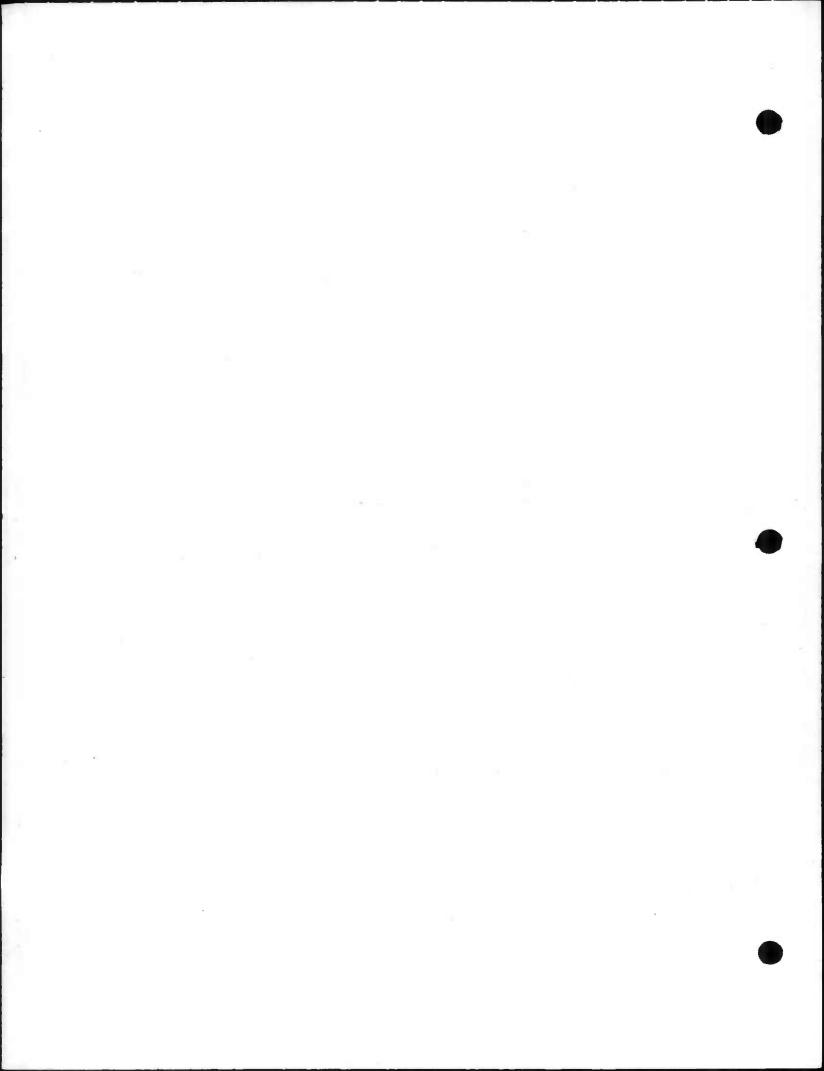
36. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

245280

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may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

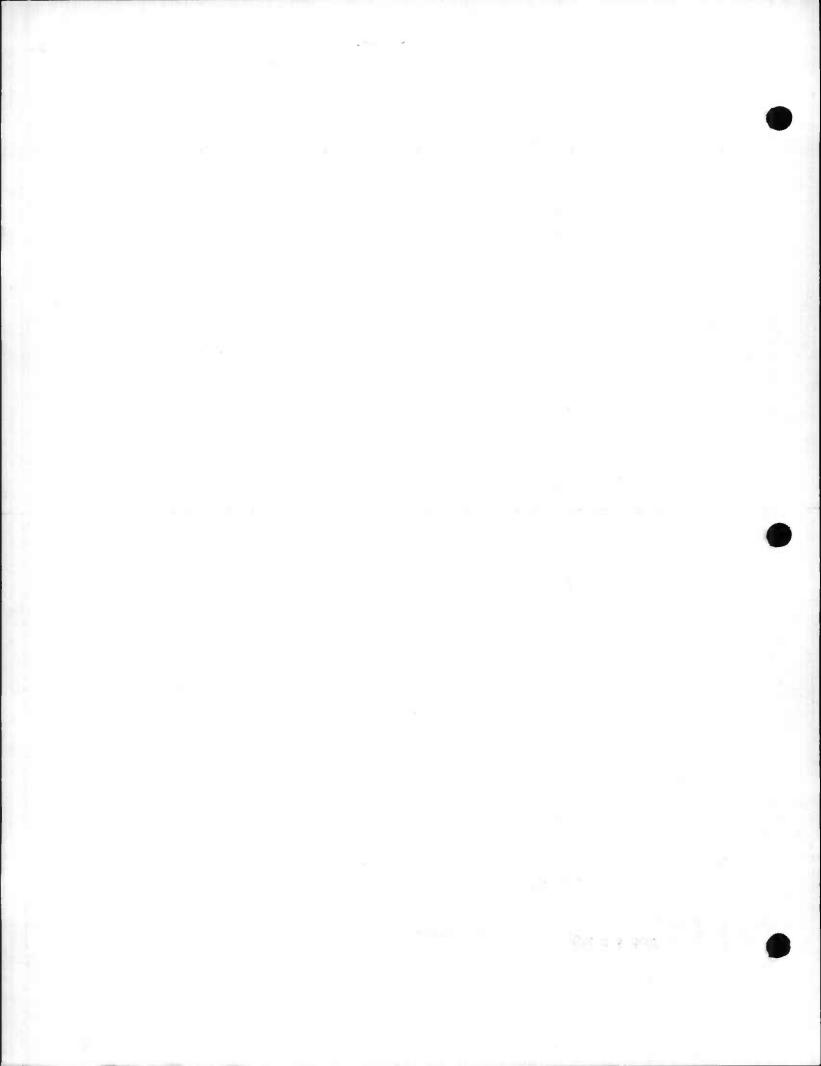
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	1. DECEDENT'S NAME (First,	Middle, Last)	EUGEN	E RUSS	ET.T. T	ממס			MONT	OF DEATH	MY 1.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. las		UNDER 1 YE	EAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		9.5 8. BIRTH	PLACE (State or Foreign
	220-34-97		Ü∏ÜM 2 ☐ F	5 5	YRS.		WS	HOURS MIN.	05	7 1 3 7 3	9		aware
OR	94. FACILITY NAME (If not in 11547 Sull:	Lnick						ersburg				tgo:	mery
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	Y		10c. CITY, T	OWN OR L	OCATI	ON	-				10d, INSIDE CITY
	Maryland	Mont	gomery				_	ithers	bur	g			LIMITS?
ERA	11547 St	111ni	ck Way				101.	20878					States
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 🖔 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W V1etNa	YES 2 1	NO	If yes	s, spe	ENDENT OF HISPAN city Cuban, Maxica 2 NO Specifi	in, Puerto	N? (Specify Ye Rican, etc.)	1	14. RACE	- American Indian, c, White, etc.
ETED	15. DEC	EDENT'S EDU	CATION	16a. DE	CEDENT'S USI	UAL OCCUI	PATIO	N .	168	. KIND OF BU	SINESS/IN	DUSTRY	
COMPLET	Elementary/Secondary (0 12th		College (1-4 or 5	-) Ilfo	ilita	tired.)	ng mos	t or working		J.S.	Air	For	се
	17. FATHER'S NAME (First, Mi		ce Russ	011 70	4 4			18. MOTHER'S NA					
8	194. INFORMANT'S NAME (7)		ce kuss			DRESS (Str	met an	Kathle					Hughes
٩	Janet Bre		e Todd		11547	Sul	. 1 n	ick Wa	у, (Gaith	ersb	urg	, MD20878
	20a, METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	20b. PLACE	metory or other	place)	N (Nan	tery 4	DAT			City or To	urg, MD
	21. SIGNATURE OF FUNERAL	SERVICE LIC				22. NAM	E AND	D ADDRESS OF FA	CILITY				
	► Mich	end 7	- Esken					\times 43,					eral Home D 21632
CATION	disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter UNDERLY!	liata NG	DUE TO	PATEC (OR AS A CONSEC (OR AS A CONSEC	ALCO			4		_			•
CERTIFIC	CAUSE (Disease or Injuithat Initiated eventa resulting in death) LAST	· •	DUE TO	(OR AS A CONSEC	OUENCE OF):								
MEDICAL (PART II. Other significan	nt condition	s contributing to	death but not r	esulting in t	ha under	lying	cause given in	Part I.	24a. WAS AN PERFOI 1 YES 2	RMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN:	25. WAS CASE REFERRED TO	MEDICAL											
SICIAN:	EXAMINER?	MEDICAL	HOSPITAL:	ER/Outpetient 3		THER:		CE OF DEATH (Che					
ВУ РНУ		ending	28a. DATE OF (Month, De	INJURY	28b. TIME OF	28c.	. INJU	RY AT IK?		CRIBE HOW I	NJURY OC	CURED	
	3 Suicide s	Could not be elermined	26s. PLACE Of building,	F INJURY — At ho atc. (Specify)	me, farm, stree	t, fectory, e	office		28t. LOC City	ATION (Street or Town, State)	and Number	r or Rurel A	oute Number,
COMPLE			CIAN: To the best of R: On the basis of ex										end manner se stated.
8	29b. SIGNATURE AND TITLE	OF CERTIFIER	/				2	29c. LICENSE NUM		9		E SIGNED	(Month, Day, Year)
유	30. NAME AND ADDRESS OF	PERSON WHO	ASH 43	Naval	Medic		Cer			Wisc			
	31. DATE FILED (Month, Day,) APR 2 8	bar)	32. REGISTRAL	H'S SIGNAFÜRE	M					esda,			889

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) Reason W Turner	2. DATE OF DEATH APRIL S. TIME OF DEATH MONTH DAY 1995 9: 40 PM							
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1. F UNDER 1 YEAR 1. F UNDER 24 HRS. 2 1 9 14 3 9 2 3 1 0 M 2 0 F 7 / YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) Country)							
Œ	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE Mar. Der Health Care	ATH Sc. COUNTY OF DEATH							
DIRECTOR	RESIDENCE OF DECEDENT 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION	10d. INSIDE CITY							
	Md Queen Anne Chester	1 PES 2 NO							
FUNERAL	1420 Cox Neck Rd. 214	10g. CITIZEN OF WHAT COUNTRY?							
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 1 Ves Q No OFFICE OF HISPAN 1 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES Q NO OFFICE								
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.)	16b. KIND OF BUSINESS/INDUSTRY							
COMPLET	12 Water man	Sestord							
BE CC	Walley Turner 1 of	ME (First, Middle, Melden Surname)							
10	190. INFORMANT'S NAME (Type/Pyth) VICGINIA TUNE 190. MAILING ADDRESS (Street and Number or Rural I	71619							
	20a. METHOD OF DISPOSITION 1 Burlar 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	DATE; 20c. LOCATION City or Town, State							
	21. SIGNATURE OF FUNERAL SERVICE LICEMSEE 22. NAME AND ADDRESS OF FA								
	23. PART i. Enter the diseases, or complications that coused the death. Do not enter the mode of dving, such	e St. Essten, md. 2/60/ h as cardiac or respiratory arrest, Approximate							
	IMMEDIATE CAUSE (Final	intervel Between Onset and Daeth							
	resulting in death) e. In eumonia DUE TO (OR AS A CONSEQUENCE OF):								
ATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Stage T4 NO MO								
CERTIFICATION	CAUSE, Chisease or injury that initiated events resulting in death) LAST								
CER	d	Don't leave we wanted							
DICA	Trackerstony	Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
PHYSICIAN: MEDICA		1 YES 2 NO							
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 1 Inperient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence	01 1 1							
	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED							
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28I. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETE	29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated.								
1 - 11	one) 2 MEDICAL EXAMINER: On the beele of axamination and/or investigation, in my opinion, death occured at the	lime, data end place, and due to like cause(e) end menner as stated.							
O BE	DRoggen MO D3S	BER 29d. DATE SIGNED (Month, Day, Year) ▶ Ap-// /8 / 1995							
	D. Roggen 17:77 Relaterstown Rd. Buttoner M	0 21208							
	31. DATE FILED (MÖRTH, Day, Year) APR 2 0 1995								

1..... See . 2 A9A

stained by the hospital or attending physician. Should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cettificate be executed within a hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical axaminat must be notified at once.
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										30	12288
	FOR STATE REGISTRAR	STATE OF M	MARYLAND /		TMENT O) MEN	TAL HYGIEN REG. NO.	_	
	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH		3. TIME OF DEATH
	RUTH JA	TRAD	ER				ril 14	1995	5:50 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER 1 Y	EAR I	F UNDER 24 HR	s. 7. D/	TE OF BIRTN		BIRTHPLACE (State or Foreign
	181-20-1728-A	1 🗌 M 2 🔀 F	91	YRS.	MONTHS D	AYS H	OURS MIN	Ar	onth Day Year)	1903	Country) MD
	9a. FACILITY NAME (if not institution, give s	treet end number)			9b. CITY, TO	OWN OR	LOCATION OF	DEATN		9c. COUNT	Y OF DEATH
Ö	Salisbury Nursing	& Rehab	Center		Salis	bury	Md.			WICC	MICO
<u>[</u>	10a, STATE 10b, COUNT			100 CIT	Y, TOWN OR I						10d. INSIDE CITY
DIRECTOR		comico			rsonsk		•				LIMITS?
1 1	10e, STREET AND NUMBER	CHILCO		10							1 TYES 2 NO
FUNERAL						4 4 4	P CODE			100	N OF WHAT COUNTRY?
W	33618 Rounds Road						849				. S. A.
3	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. ARA		13. WAS	S DECENI	DENT OF HIS by Cuban, Me:	PANIC OR	GIN? (Specify Yearlo Rican, stc.)	or No- 14	4. RACE — Americen Indien, Black, While, etc.
ВУ	3 XWidowed 4 Divorced	IF YES, GIVE W	AR OR DATES				NO Sp				Specify:
ED E	15. DECEDENT'S EDU	CATION	44- 050	COENTIO	USUAL OCCL	10 ATL 014					fro-American
1	(Specify only highest grade	completed)	(Gh	re kind of	work done duri se retired.)	ing most o	of working		16b. KIND OF BU	SINESS/INDUS	STRY
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 -	+)		estic				Domes	tic (I	Dr. Mitchell)
COMPLET	17. FATHER'S NAME (First, Middle, Last)			DON	estic						or. Firecircus
8	Samuel Smith					1			st, Middle, Meiden	Surneme)	
H						Щ.,			Gordy		
2	190. INFORMANT'S NAME (Type/Print) Otis Smith								onsburg		21849
								rara			
	20e. METHOD OF DISPOSITION 1 Burlei 2 Cremetion 3 Rem	oval from State	20b. PLACEA								urg, MD
	4 Donation 5 Other (Specify)	SENORE /) Piass						22 202		
	21. SIGNATURE OF FUNERAL SERVICE LIN	ENSEE			22. NA	ME AND	ADDRESS OF	FACILITY	Fooks F	unera:	l Service
	Jussell.	0100	1		917	W.	Isabel	lla S	Street -	Salis	sbury, MD
	23. PART I. Enter the diseases, or	complications tha	t ceused the dea	th. Do							it, Approximets
	ahock, or heart failure. IMMEDIATE CAUSE (Finel	*									Interval Between Onset and Death
	disease Dr condition	Sum	ed Dar	277	00	2nd	shle	1	11		7.4/28
	resulting in death) But To (OR AS A CONSEQUENCE OF):										
-	IMMEDIATE CAUSE (Fine) disease of condition resulting in death) a Supper Death Probable MI THRS DUE TO (OR AS A CONSEQUENCE OF): L(STORY CHE, Ventroller Maying CARDA Due TO (OR AS A CONSEQUENCE OF): If any, leading to immediate										
ERTIFICATION	Sequentially list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):										
X	cause. Enter UNDERLYING										
핕	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):						
F	resulting in death) LAST	d									!
빙	a										
A	PART II. Other significent condition	e contributing to	death but not re	euiting	in the unde	riying c	euse given	in Part I	. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
용	/+ (1-7 S) 1 TYES 2 NO COMPLETION OF CALL								COMPLETION OF CAUSE OF DEATH?		
MEDICAL	Mense &	melun									1 TES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	TH YE	S 🗆 NO	od	UNCERT	AIN 🗆			/
N N	25. WAS CASE REFERRED TO MEDICAL				TN (Check only						
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	n Home	5 □ Baelden	ce s 🗆 f	ther (Specify)		
ξļ	27. MANNER OF DEATH	26a. DATE OF	INJURY	28b. TIM	E OF 28	e. INJUR	Y AT		DESCRIBE HOW I	NJURY OCCU	RED
	1 Natural 5 Pending	(Month, D	lay, Year)	IN.	URY	WORK	7 3 2 NO				
Accident Investigation 28- DLACS OF IN HIDY. As borns form detail feeling office.							and Number or	Pural Bruta Number			
9	3 Suicida 6 Could not be 4 Nomicide datermined	building,	etc. (Specify)	sattley		,			City or Town, State)		Course (success),
E	200 CERTIFIER										
COMPLET	ana)	ICIAN: To the best of									
8	one) 2 MEDICAL EXAMINE	R: On the beele of e	xemination end/or in	rveatigatio	n, in my opin	ilon, dest	h occured at	the time,	late end plece, en	d due to the	ceuse(s) end menner ee atated.
C	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,				SIGNED (Month, Day, Year)		
8	w	ath	am			Г	3981	3		14	114/98
임	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CALL		27) /Trpe	Orint)	11	, 5,01			U	

1104 HEALTHWAY DR., SALIABURY, Md.

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

32 MEGISTRAR'S SIGNATURO

M.D.

MICHAEL ATKINS,

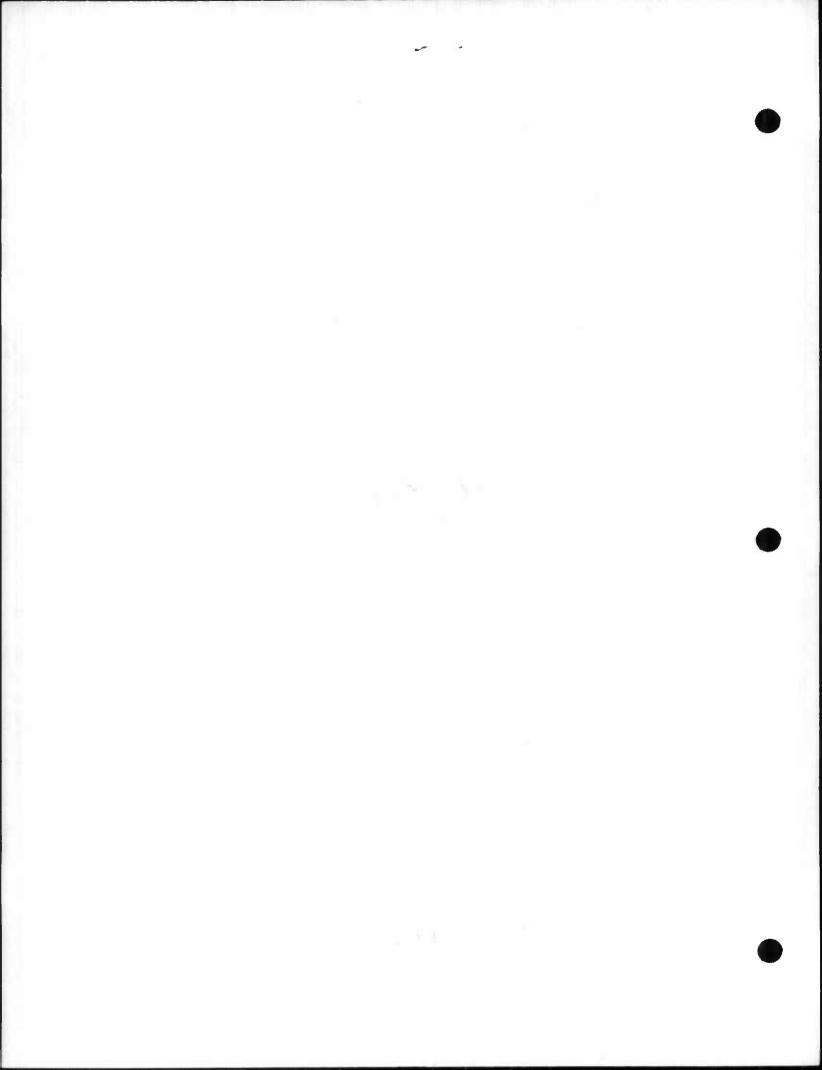
31. DATE FILED (Month, Day, Year)
APR 2 7

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE O	F DEATH	REG. N	O.				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
		Oscar George Ta	ate				April (9 19	95 2310 M			
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEA	IF UNDER 24 HRS.	7. DATE OF BIRTH	8	BIRTHPLACE (State or Foreign			
_		220-12-1476	1X M 2 🗆 F 91	YRS.	MONTHS DAY	HOURS MIN.	May 9, 190	2	country) Marvland			
2, 3 should		9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOW	N OR LOCATION OF DE			Y OF DEATH			
en .	JR.	The Kent & Queen Anne's Hospital Inc. Chestertown Maryland Kent										
	DIRECTOR			di ilic.	Oneste	T COMIT TIQT	yrana	INCITO				
ages	문	10s. STATE 10b. COUNTY	r		Y, TOWN OR LO				10d. INSIDE CITY LIMITS?			
permit. Pages 1,		Maryland	Kent		Milling	gton			1 TES 2 NO			
Ded.	¥	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?			
physician. burial-transit	FUNER	10616 Chestervill	.e Road			21651		Unite	d States			
physician. burial-trar	5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS D	ECENDENT OF HISPAN	IIC ORIGIN? (Specify	fea or No — 14	Black, White, etc.			
D D	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 _ Y	specify Cuban, Mexica ES 2 NO Specify		1	Specify:			
attending se as the	ED 8		<u> </u>						Black			
use use		15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	work done during	TION most of working	16b, KIND OF E	USINESS/INDUS	STRY			
	12	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT us								
the hospital detached it	COMPLET	17. FATHER'S NAME (First, Middle, Last)		Labore	er			ructio	n			
by the		Oscar Tate					ME (First, Middle, Meidle 7a Wilson	en Surname)				
bed b	BE	19a. INFORMANT'S NAME (Type/Print)										
5 should notified	2	Bernice Tate				et and Number or Rural F			Maryland 21651			
age a		20g. METHOD OF DISPOSITION										
age 6 may be director, page er must be		1 X Burial 2 Cremation 3 Rame	oval from State Cer	b. PLACE AND DATE (metery, crematory or o	ther niecel		3		y or Town, Stata			
Page Il direc		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		soury Ceme		oril 15, 199		sterville	rville, Maryland			
death. Pag tuneral dii examiner		N	1.1	4001	Fello	AND ADDRESS OF FAC	1 Homes.	P.A.				
		William L. King Jr 370 Cypress Street, Millington, Maryland 21651										
m > 6 43		23. PART i. Enter the diseases, or o	omplications that cause	d the death. Do	ot enter the r	node of dying, aucl	as cardiac or rea	piratory arrea	t, Approximata			
D D D E		23. PART I. Enter the diseases, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each little. IMMEDIATE CAUSE (Final										
		disease or condition resulting in death) DUE TO (9R AS A CONSEQUENCE OF): DUE TO (9R AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
		resorting in death)	DUE TO (OR AS	A CONSEQUENCE OF	P. /	eum .						
ecuted ind cor bunal,	z		Rose	ut cv	AC	At Ho	and let					
8 5 5 E	CERTIFICATION	Sequentially list conditions, if any, leading to immediate		A CONSEQUENCE OF	F):		Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan					
	2	cause. Enter UNDERLYING CAUSE (Disease or injury										
h certifica anding phy Hygiene or other	틸	that initiated events Due TO (OR AS A CONSEQUENCE OF):										
	H	resulting in death) LAST	1									
the death y the atte od Mental		PART II. Other aignificant condition	s contributing to death I	out not resulting i	in the underly	lag cours shap in	Post I Day 1990 a	AL ALEMANA V				
the party	MEDICAL		Chrotic (PERF	N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
es the	à			androl	rascu	lan grace	1 TYES	2 10	OF DEATH?			
requires been sign or Healt	Σ	(2) Daheles	Mellitus						1 _ YES 2 _ NO			
law lep	Z	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C				10					
SICIAN: The last certificate has the State Dept. 1, or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:	(0)						
ician ertific the S	ΙΥS	1 TYES 2 THO	1 Pinpetient 2 ER/Out		4 - Nursing H	ome 5 🗆 Residenca	6 Other (Specify)					
S C ==		27. MANNED OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	NJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCUP	RED			
This with	~ 1		l l		YES 2 NO							
ther this c eath with marked,	β¥	2 Accident Investigation										
TENDING PHY OR: After this fter death with		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF INJURY building, etc. (Spec	f — At home, larm, s cify)	street, lactory, of	fica	261. LOCATION (Stree City or Town, Stat		Rural Route Number,			
TTEND CTOR: A after d		3 Suicide 6 Could not be determined	building, etc. (Spec	cify)			City or Town, Stat	•)	Rural Route Number,			
OR OIR		3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only)	building, etc. (Special CIAN: To the best of my know	cify) rledge, death occurre	ed at the time, do	its and place, and due	City or Town, Stal	enner as stated.				
TAL OR VAL OIR 72 hour If Iten		3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only)	building, etc. (Special CIAN: To the best of my know	cify) rledge, death occurre	ed at the time, do	its and place, and due	City or Town, Stal	enner as stated.	Rural Route Number,			
TAL OR VAL OIR 72 hour If Iten	COMPLETED	3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only)	CIAN: To the best of my know	cify) rledge, death occurre	nd at the time, do	its and place, and due, death occured at the	City or Town, Stall to the cause(a) and millime, data and place,	enner as stated.				
THE HOSPITAL OR THE FUNERAL OIR Tiled within 72 hour PORTANT: If Iten	BE COMPLETED	3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my know	cify) rledge, death occurre	nd at the time, do	its and place, and due, death occured at the	City or Town, Stall to the cause(a) and millime, data and place,	enner as stated.	ause(s) and manner as stated.			
TAL OR VAL OIR 72 hour If Iten	COMPLETED	3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	CIAN: To the best of my know R: On the basis of examination COMPLETED CAUSE OF DE	city) riedge, death occurre on and/or investigatio	nd at the time, do	its and place, and due, death occured at the	City or Town, Stall to the cause(a) and millime, data and place,	enner as stated.	ause(s) and manner as stated.			
THE HOSPITAL OR THE FUNERAL OIR Tiled within 72 hour PORTANT: If Iten	BE COMPLETED	3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my know R: On the basis of examination COMPLETED CAUSE OF DE	city) riedge, death occurre on and/or investigatio	nd at the time, do	its and place, and due, death occured at the	City or Town, Stall to the cause(a) and millime, data and place,	enner as stated.	ause(s) and manner as stated.			
THE HOSPITAL OR THE FUNERAL OIR Tiled within 72 hour PORTANT: If Iten	BE COMPLETED	3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	CIAN: To the best of my know R: On the basis of examination COMPLETED CAUSE OF DE	city) riedge, death occurre on and/or investigatio	nd at the time, do	ite and place, and due, death occured at the	City or Town, Stall to the cause(a) and millime, data and place,	enner as stated.	ause(s) and manner as stated.			



STOUR BALLIMOHE, MARYLAND 21215-0020	fled withling a hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fir be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal,	IMPORTANT: It from 28 is marked, or from 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF					ITAL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) HELEN M.	V M. THOMPSON MONTH PLAY 7, 19								3. TIME OF DEATH		
œ	000 00 0000	6. AGE (fn yrs. lest birthday) 5 YRS.	IF UNDER 1	DAYS HOURS MIN. 7. DATE OF BIRTH (Month, Day, Year) Sept. 15,1909 Ohio							
	90. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH Shady Grove Adventist Hospital Rockville								9c. COUNTY	Y OF DEATH		
CTO	RESIDENCE OF DECEDENT	ventist H					е		Mon	ntgomery		
DIRECTOR	Maryland Mont	gomery		v, rown or aithe						10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
	100. STREET AND NUMBER		1.2		10f. 2	ZIP CODE				N OF WHAT COUNTRY?		
FUNERAL	407 Russell Avenue - #213 11. Marital status 12. Was decedent ever in u.s. armed 13. Was			AS DECEN	208		RIGIN? (Specify Yes		S.A.			
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 N YES IF YES, GIVE WAR OR DA WORLD WAR	2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) ITES 1 YES 2 NO Specify:						Black, White, etc. Specify: White			
COMPLETED	16. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of ville, Do NOT us Homem	work done du se retired.)	iring most	of working		166, KIND OF BUS				
OM	17. FATHER'S NAME (First, Middle, Last)				1	18. MOTHER	'S NAME (F					
BE C	Raymond D. Ho:	lcomb						ME (First, Middle, Malden Surname) rude M. Overholt				
5	190. INFORMANT'S NAME (Type/Print) Leslie B. Thomp	oson						Number, City or Town — 世 2 1 3 . (
	20e. METHOD OF DISPOSITION RENDERED 2 □ Cremetion 3 □ Remove	20b.	PLACEANDDATE	OF DISPOSIT	ION (Name	e of		0ATE 200 LOC	ATION - CIN	u or Town State		
	MCMBurlet 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) Damascus Methodist Cem. 5/10 Damascus, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Sequents Seque											
PHYSICIAN: MEDICAL CERT	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO				
SICI	EXAMINER? H	OSPITAL:	titlent 3 DOA	OTHER:		5 Poolds	non 6 🗆	Other (Specify)				
PHY	27. MANNER OF DEATH Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM		8c. INJUR WORK	RY AT		DESCRIBE HOW IN	JURY OCCUR	IEO		
B	Accident Investigation	28e. PLACE OF INJURY	— At home, farm, a			S 2 N						
	4 Homicide 8 Could not be datermined	building, atc. (Speci	fy)		,,		201.	City or Town, State)	o warnos or r	autai rioute rumoei,		
COMPLETE		N: To the best of my knowle								ause(e) end manner as stated.		
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER				2	9c. LICENSE	NUMBER		29d. DATE SI	IGNED (Month, Day, Year)		
0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					DZ	730	/	ma	Black, White, etc. Specify: White ESS/INDUSTRY home. Maryland A. Funeral Home mascus, Maryland A., Funeral Home mascus, Maryland ory arrest, Approximata interval Between Onset and Death COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO DAY OCCURED Number or Rural Route Number, r as stated. use to the cause(e) end manner as stated. Bd. DATE SIGNED (Month, Dey, Year)		
	Days 435 R. S.	WM OKE	(TEM 27) (Type,	Ros	5 CHE 0	WILL	E.	MO 2	RY ,	ENE.		
	31. DATE FILED (Month, Day, Year) MAY 1 0 1995	32. REMSTRAN'S SIGNA	TURE ROALIE	ì								

ifbe at 1362) III .

FOR

1 - STATE REGISTRAR		SINIE UF I	WANTE	CERTIF					MENIAL	REG. NO				
1. DECEDENT'S NAME (First	, Middle, Last)									OF DEATH			3. TIME OF DEATH	
i	IOHN	I.FON T	PERT (N Tra7					Мач	_		995	7:00 p	
4. SOCIAL SECURITY NUME		5. SEX		In yrs. last birtnday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE (OF BIRTH		8. BIRTI	IPLACE (State or Foreign	\dashv
422-38-2647	7	1 € M 2 □ F	63	YRS.	MONTHS	DAYS	HOURS	MIN.		2, 19	131	New		ı
9a. FACILITY NAME (If not in		street and number)			9b. CITY,	TOWN O	R LOCATIO			2, 13		UNTY OF E		\dashv
618 Law	Stree	et			D	ber	deen					larfo	rd.	
RESIDENCE OF DEC	10b COUNT											larro		\exists
	-108, COUNT		_	10c, Cl	TY, TOWN O	R LOCATI	ON						10d. INSIDE CITY LIMITS?	
Maryland		Harford	<u>k</u>		Aberc	-							TXXYES 2 NO	
	~.					101.	ZIP CODE	5			10g. Cl	TIZEN OF	WHAT COUNTRY?	1
618 Law	Street	12. WAS DECEDEN	T EVED II	III O ADMED	1 40 1		2100					S.A.		_
1 Never Married 2	Merried	FORCES?	YES	2 NO	H	yes, spe	city Cubar	n, Mexice	n, Puerto R	? (Specify Yes lican, etc.)	or No—	Blac	E — American Indian, k, White, etc.	
3 Widowed 4 Divo	orced	Korear		ATES	'	YES	2XXN0	Specify	y:			Spec	;; ite	
15. DEC	EDENT'S EDU y highest grade	CATION		16e. DECEDENT	USUAL OC	CUPATIO	N		16b.	KIND OF BU	SINESS/IN		1.66	\dashv
Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT	work done duse retired.)	luring mos	it of working	g						
12		0		Produc	tion	Fore	eman		N	lanufa	ctur	ing		
17. FATHER'S NAME (First, M						11.0		ER'S NA	ME (First, M	liddle, Melden	Sumame)			٦
Frank Te							A	lma	Bale	es				
19a. INFORMANT'S NAME (19b. MAILIN	G ADDRESS	(Street er	nd Number	or Rural I	Route Numb	er, City or Tow	n, State, Z	(p Code)		
Mrs. Lucy	M. Te	erlouw		618	Law	Stre	et,	Abe	rdeer	, Mar	ylan	d 2	1001	
20e. METHOD OF DISPOSIT		oval from State		PLACE AND DATE		ITION (Nat	ne of		DATE	20c. LO	CATION -	- City or To	own, State	٦
ty Buriel 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			T	abernác	le Ce				5/9	Whi	tefo	rd.	Maryland	
21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE /		4			D ADDRES		CILITY	ral H				
Birst	in A	ous (1	Mal	eske	Ab	erde	en.	Mary	yland	210	01-3		•	- 1
23. PART i. Enter the d	iseeses, or	complications the	t caused	the deeth. Do	not enter	the mod	ia of dyle	ng, suc	h as card	lac or resp			Approximata	٦
IMMEDIATE CAUSE (Fir		List Dniy Dne car						/					interval Between Onset and Deat	
disease or condition resulting in death)	→	MET	YAS.	M770		Co	LUN	\checkmark	CA	NCE	rc.		17/2 TEA	es
resolding in death)	,			CONSEQUENCE									1	\dashv
		b.												
Sequentielly list condit if any, leading to imme	diate	DUE TO	(OR AS A	CONSEQUENCE	P):									П
cause. Enter UNDERLY		G												
that initiated events resulting in deeth) LAS		DUE TO	(OR AS A	CONSEQUENCE	OF):									
resulting in deetin, EAS		d												
PART II. Other significe	ent condition	ns contributing to	deeth b	Ut not resulting	in the un	derlying	cauee g	iven in	Part i.	24a. WAS AN	AUTOPSY	241	. WERE AUTOPSY FINDINGS	H
										PERFOR			AMILABLE PRIOR TO COMPLETION OF CAUSE	
									-	1 YES 2	NO		OF DEATH?	ı
DID TOBACCO	USE C	ONTRIBUTE	TO (CAUSE OF	DEATH	- YE	S	NO					1 YES 2 NO	
25. WAS CASE REFERRED T									eck only one	9)				\dashv
EXAMINER?		HOSPITAL:	ER/Outo	atlent 3 DOA	OTHER	t:			6 🗆 Other					┪
27. MANNER OF DEATH		26e. DATE OF	INJURY	26b. TI	WE OF	28c. INJL	JRY AT			CRIBE HOW I	NJURY O	CCURED		\dashv
	Pending Investigation	(Month, L	/ay, 16a/)		JURY	1 🗌 Y	RK? ES 2	NO						1
a Deviate	Could not be	28e. PLACE (OF INJURY	— At home, term,	atreet, fecto	ory, office						er or Rural	Route Number,	┪
	determined	Dunung.	etc. (Spec	:ну)					City a	or Town, State)				1
29e. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best o	my know	edge, death occur	red at the 1	me dete	and place	and due	to the cau	sa(a) and ma	nner ee et	eted		7
													s) end menner se stated.	-
296. SIGNATURE AND TITLE				2			No. LICE							4
1177=	1 -1	11/1	1		_		7)	Z/	77	5	Zad. DV	TE STUNE	(Month, Day, Year)	-
38. NAME AND ADDRESS OF	F PERSON WH	IO COMPLETED CAU	SE OF DE	ATH (ITEM 27) (Two	e, Print)		-9		//			J -	0 70	-
JOAN PO	Acus A	RDS M	0		BEL	1	R	T	Fai	CT	04)	MI	21840	
31 DATE FILED (Month, Day,		32. RIFGISTR	I S SIGN	ATURE Parket	200	<i>*=</i> []/*		-1,0	1 17 (-	1 6	7/0 '	111)	LIUN	4
MAY	8 199	5 Jahra	Thurs	iar Karball									1	

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within. Durs after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR	CERTIFI	CATE OF	DEATH	MENIAL	REG. NO.	_					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	DEATH			3. TIME OF DEATH			
	CHARLES PHILLIPS	TYLER	JR.		0.5	04		95	17:10P M			
		GE (In yrs. lest birthday) . 7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, I May	BIRTH Pay, Year) 18 19	77	e. BIRTHE	LACE (State or Foreign			
TOR	sa. FACILITY NAME (If not institution, give street and number) ROUTE, 343 RESIDENCE OF DECEDENT		9b. CITY, TOWN	OR LOCATION OF D			9c. COU	NTY OF DE	ATH			
DIRECTOR	100. STATE 10b. COUNTY Maryland Dorchester	10c. CITY	Cambri					T	10d. INSIDE CITY LIMITS?			
FUNERAL	100. STREET AND NUMBER 203 Sandy Hill Rd.		10	1. ZIP CODE 2161	.3			1 ☐ YES 2次 NO CITIZEN OF WHAT COUNTRY? U.S.A.				
à	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES, GIVE WAR O	ES 2 NO	If yes, sp	CENDENT OF HISPA ecity Cuben, Maxico 2 X NO Specia	en, Puerto Ric			14 BACE	- American Indian, White, atc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)	18a. DECEDENT'S U (Give kind of w life. Do NOT use Stud	ork done during mo retired.)		16b. K	IND OF BUS	SINESS/INC	DUSTRY				
CON	17. FATHER'S NAME (First, Middle, Last) Charles Phillips Tyler 18. MOTNER'S NAME (First, Middle, Maiden Surname) Mary Ann Elliott											
TO BE	19a. INFORMANT'S NAME (Type/Print) Mrs. Many App. Tylor			ind Number or Rural								
	Mrs. Mary Ann Tyler 203 Sandy Hill Rd., Cambridge MD 21613 204, METHOD OF DISPOSITION DATE 205, LOCATION - City of Towns, St.											
	4 Donation 8 Other (Specify) Dorchester Memorial Park 5/8 Cambridge Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	I Kreneth R Thomas	S.		s Funera ocust St			e MD	2161	3			
	23. PART I. Enter the diseases, or complications that caushock, or heart failure. List only one ceuse of IMMEDIATE CAUSE (Final disease or condition resulting in death)	n esch line.			ch ss cardia	c or respi	ratory er	est,	Approximate Interval Between Onset and Daath Instan			
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
rnisician: medical	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. 24a. WAS AN AUTOPSY PERFORMED? YES 2 \(\subseteq \text{NO} \)								WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)											
200	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/C 27. MANNER OF DEATH 28s. DATE OF INJUI	Outpatient 3 DOA			6 Other (S		ROAD					
10	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	S 28b. TIME	IRY WO	RK?	MOTO		HICL		COLLISION			
	3 Suicide 8 Could not be 4 Nomicide 8 detarmined	Specify) At home, farm, at 5 7 Q			28t. LOCATION OF THE PROPERTY	ON (Street a. fown, State)		or Aural Ac				
COMPLETE	29e. CERTIFIER (Check only one) 1								and manner as stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI					Wonth, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type I	Print)	O.C.M.	E		MA	Y 05	1995			
	1	11 Penn		, Balt:	imore	, Ma	ryla	nd 2	21201			
	31. DATE FILED (Morith, Day, Year) 32 REGISTRAR'S, SI	GNATUBE LOC NOVOALL										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

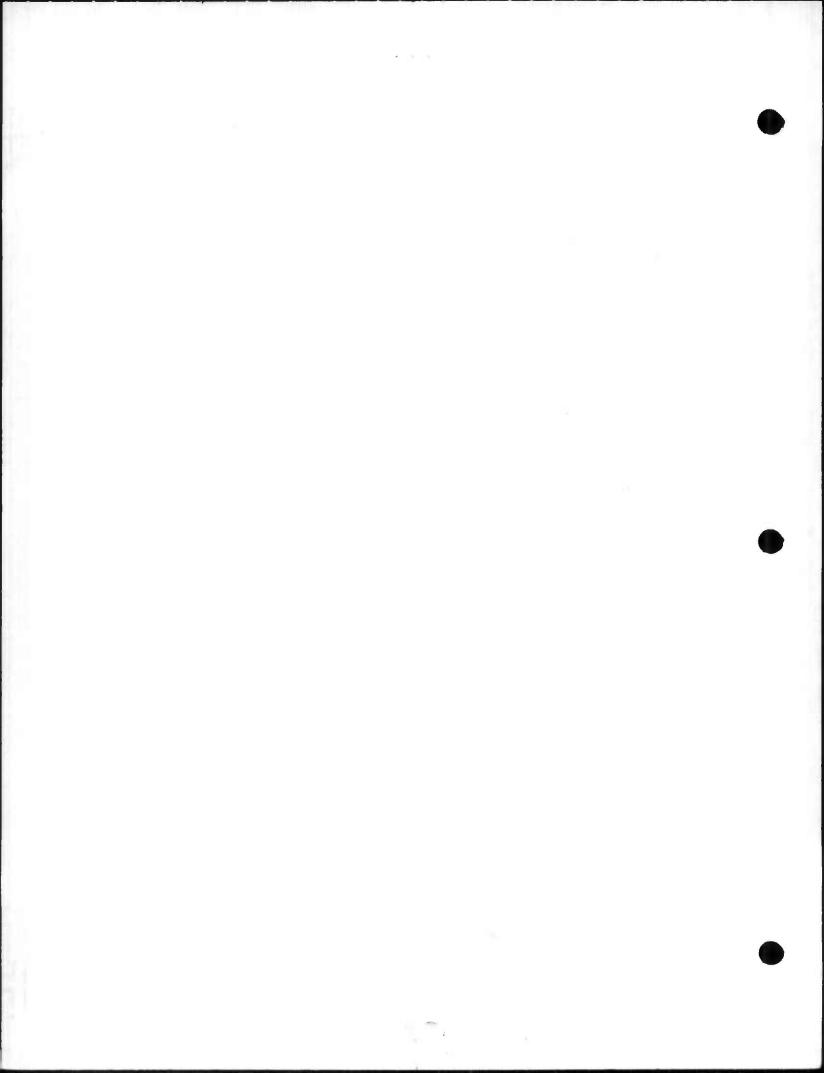
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 8

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	TMENT OF H	HEALTH AND	MENTAL	HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last	R. VINES				2. DATE	OF DEATH		YEAR 3.	TIME OF DEATH		
6 0/	6	4. SOCIAL SECURITY NUMBER 242-54-4993 98. FACILITY NAME (If not institution, give	5. SEX 6. AGE (III	n yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Dec	DE BIRTH Day, Year) 3, 19	39 1	Country)	ACE (State or Foreign		
1, 2, 3 sho	CTOR	LAUREL REGIONAL							9c. COUNTY OF DEATH PRINCE GEORGES				
Pages	DIRE	NA NA NA			Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 X YES 2 N				
in. ransit permit.	FUNERAL	100. STREET AND NUMBER 2 (02	ENUE, N.W. APT		101	20001			109. CITIZE		TATES		
21215-0020 Il or attending physician. for use as the burial-transit	₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 🖔 Divorced	12. WAS DECEDENT, EVER IN FORCES? 12 YES IF YES, GIVE WAR OR DA	2NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Sp						American Indian, White, atc.		
	LETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION fe completed) College (1-4 or 5+)	life. Do NOT us	vork done during mo	est of working			SINESS/INDU	BLACI			
MARYLAND 2 retained by the hospital 5 should be detached to	at once.	17. FATHER'S NAME (First, Middle, Last) CHARLIE VINES		18. MOTHER'S NA	ME (First, M		_						
60 (0)	TO B	19a. INFORMANT'S NAME (Type/Print) WILLIE E. VINES	MARTHA WALSTON 196. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Co. 7113 KENT TOWN DR., LANDOVER, MARYLAI								7785		
ALTIMORE, leath. Page 6 may be funeral director, page	er must be	20e. METHOD OF DISPOSITION 1	moval from State	PLACE AND DATE CONTROL OF STATE CONTROL CONTRO	PETERY	ame of	5/5	20c. LO	CATION — CH	y or Town,	, State		
BA ter de the fu	ai examiner	· alex & Pyl	e fr	M859	ALEXA 5538	NDER S. MARLBORG	POPE PIKE	E, FOR	ESTVI	LLE.	MD 20747		
. BOX 68760 ficate be executed within 24 hours af physician and completely filled in by ne prior to burial, cremation, or enm	traumatic event, the medical	23. PART I. Enter the diseases, or shock, or heart feiture iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING	a. Renal	CONSEQUENCE OF	Adence						Approximata interval Between Onset and Deat		
P.O. ath certific ttending p	or other	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A (CONSEQUENCE OF):								
. RECORDS, P w requires that the death been signed by the atter pt, of Health and Mental I	shows any injury. MEDICAL CE	PART II. Other aignificent condition	na contributing to death bu	it not resulting i	n the underlying	g cause given in		24a. WAS AN PERFOR	MED?	CO	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO		
TAL The la	r Item 23 s SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEAT		UNCERTAIN	N DK						
OF V PHYSICIA this certif with the	PHY	1 VSS 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/Outper 26a. DATE OF INJURY (Month, Day, Year)	28b. TIME	4 Nursing Hom OF 26c. INJ	URY AT RK?	_		JURY OCCUI	RED			
DIVISION OR ATTENDING DIRECTOR: After hours after death	28 is	Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY - building, etc. (Specif	At home, farm, st			28t. LOCA City o	TION (Street a Town, State)	nd Number or	Rural Route	Number,		
7 42	티크		SICIAN: To the best of my knowle ER: On the bests of exemination								d manner as stated.		
TO THE HOSPITA TO THE FUNERA De filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE	es N			DAS"	13 6		D 4	1/29	onth, Day, Year)		
(-		John MA 31. DATE FILED (Month, Day, Year)	RGOLLS 17	1333 L	aura b	Zue Re	1#3	67 2	leviel,	MP	20708		
P		MAY 03 1995	132. REGISTRA'S SIGNAL	OHE									



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an analysis of the retained by the hospital or attending physician.

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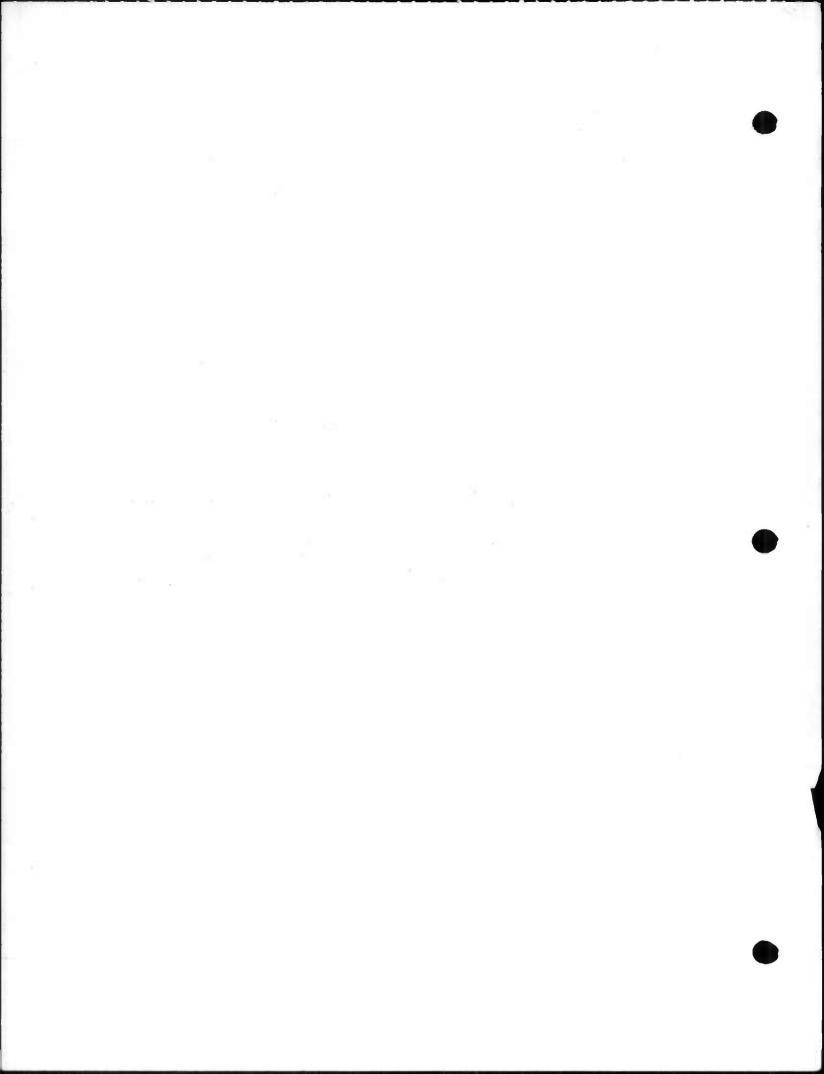
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	CENTIFI	CALE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (Bipst, Middle, Last) VERS	FEE.	9		2. DATE OF OEATH MONTH D	AY C	3. TIME OF DEATH 11:39 PM	
	079-28-2539 18M2 OF 59	s. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	NTHS DAYS HOURS MIN. (Month, Day, Year) June 13, 1935 Holls				
	9e. FACILITY NAME (If not institution, give street end number)		9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COU	NTY OF DEATH	
DIRECTOR	Holy Cross Hospital		Silver Spring				ontgomery	
#	10e. STATE 10b. COUNTY	10c. CITY	, TOWN OR LOC	TION			10d. INSIDE CITY LIMITS?	
	Maryland Montgomery		Silver				1 X YES 2 NO	
FUNERAL	10s. STREET AND NUMBER		1	of. ZIP CODE			ZEN OF WHAT COUNTRY?	
빌	1500 Flora Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S			20910			S.A.	
	1 Never Merried 2 X Merried FORCES? 1 X YES 2	□ NO	If yes, s	pecify Cuben, Mexico	NIC ORIGIN? (Specify Yea on, Puerto Rican, etc.)	or No-	14. RACE — American Indian, Black, White, etc.	
B	3 Wildowed 4 Divorced 1958-1961		1 U YE	S 2 1 NO Specif	y:		SpecMy: White	
COMPLETED		. DECEDENT'S I	USUAL OCCUPAT ork done during ri retired.)	ION ost of working	16b. KIND OF BU	SINESS/IND		
PLE	Elementary/Secondary (0-12) College (1-4 or 5+)				Fadam	1 0-		
OMI	17. FATHER'S NAME (First, Middle, Last)	rogram	Analys		ME (First, Middle, Meiden		vernment	
	Meyer Versteeg			Paula	Mosbac	,		
) BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street		Route Number, City or Tow		Code)	
2	Jo Ann L. Versteeg	1500 E	flora L	ne Silv	er Spring,	Marv	land 20910	
		CEANDDATEO	F DISPOSITION (A				City or Town, State	
	4 Donetion 5 Other (Specify)	crematory or oth ropolit	an Crei	natory 5/	2/95 Alex	andr:	ia,Virginia	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	11		ND ADDRESS OF FA	cury lins Funer	-a1 H	ome Inc	
	Mark J. Malle	2					Spr.,MD 20901	
	23. PART I. Enter the diseases, or comprisetions that ceused the ahock, or heart fellure. List only one make on each	death. Do no	ot enter the m	ode of dying, auc	h sa cardiac or reap	iratory srr	est, Approximata	
	IMMEDIATE CAUSE (Finel	1 -W	11	A.	00.		Interval Between Onset and Death	
	disease or condition s.	0/10	your	MANA	1 mels	chal	rais / My	
	OUE MI ON AS A CON	REGUENCE OF	1-1	0.100	. 11 10		Pier Min	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	ISEQUENCE OF	Cerc	acian	y corre	uya	weave you	
CA	Cause, Enter UNDERLYING CAUSE (Disease or Injury			(J			
F	that initiated events resulting in death) LAST	SEQUENCE OF):					
5	d							
	PART II. Other significant conditions contributing to deeth but n	ot resulting is	n the underlyle	ig cause given in	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
EDICAL					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEC						X	OF DEATH?	
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH YES	S NO [UNCERTAIL	N D			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		H (Check only one)				
YSI	1 YES 2 NO 1 Inpetient 2 VER/Outpetien			ne 5 🗆 Reeldence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26b. TIME	JRY W	JURY AT DRK? YES 2 NO	26d. DESCRIBE HOW I	NJURY OCC	URED	
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — A building, etc. (Specify)	1 home, term, st	treet, lectory, offi	CO	281. LOCATION (Street of City or Town, State)	and Number	or Rural Route Number,	
٦	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge	, death occurre	d at the time dat	and place, and due	to the cause(s) and may	nor on state	-1	
COMPLET	one) 2 MEDICAL EXAMINER: On the been of exemination and							
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	er	MY	29c. LICENSE NUI	ABER (1)	29d. DATE	SIGNED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH OF A LAN 1. KERMALER 103	(ITEM 27) (Type)	GARG	CIAA	VE. 5.5	. N	16 2090 >-	
	31. DATE FILED (Month, Day, 1904) 32. REGISTRAR'S SIGNATUR MAY 02 1005							
	THE WAY WAY IN THE TANK THE THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK THE TANK TH	- A. Anna A						

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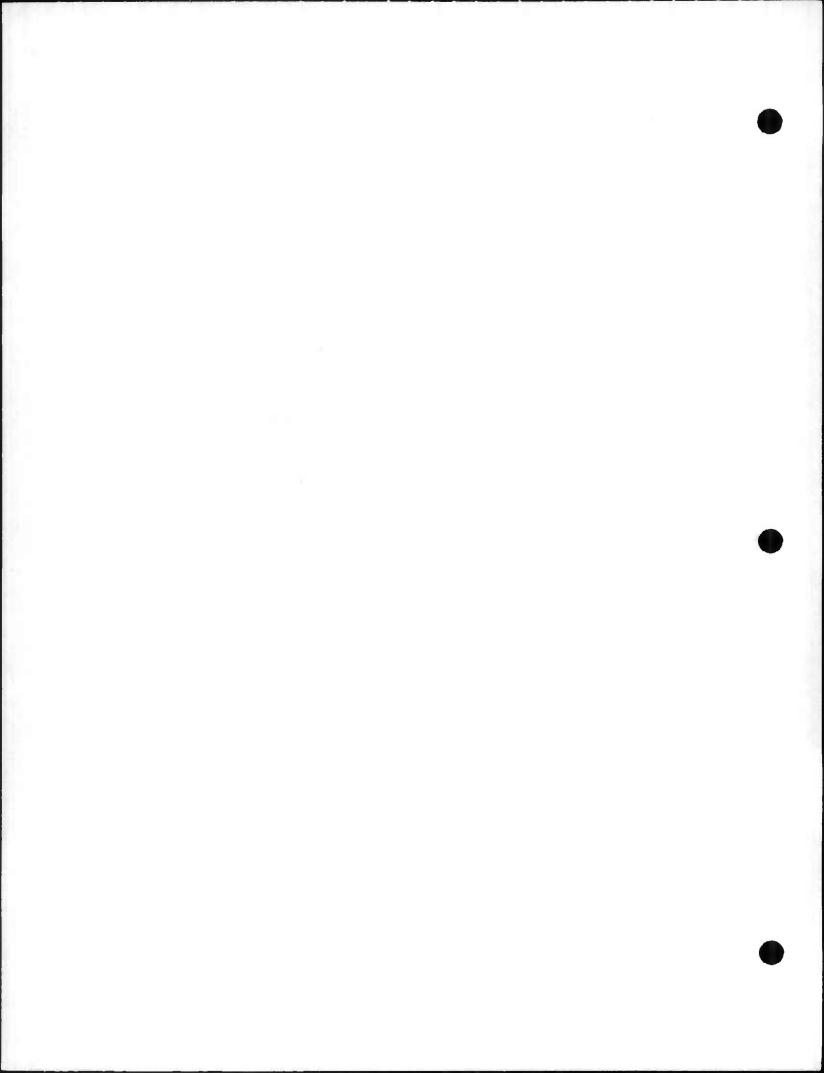
ir death. Page 6 may be retained by the hosp	he funeral director, page 5 should be detached	examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dent, or Health and Mental Hodelse prior to burial, cremation or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

Amended # 19b 5/3/95 MRT Montgomery

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

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	TEGIOTI DUT				CENTII	ICALL	_ Ur	DEA	LIT		REG. NO.			A
	1. DECEDENT'S NAME (First, SEYMOUR	Middle, Last) DAY	VES	STERM	IARK,	IR.				2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER				s. lest birthday	IF UNDER	1 VEAR	IF UNDER	24 MDR	APR]		29,1		11:20 A M
	217-32-7923	3	1 ☑ M 2 ☐ F	61		MONTHS	DAYS	HOURS	MIN.	(Month, E	Jay, Year)	022	Count	γ)
	9a. FACILITY NAME (If not in		reet and number)			9b. CITY	TOWN	OR LOCATI	ON OF DE	June 8, 1933			NTY OF D	York
DIRECTOR	8615 IRVIN	IGTON										OMERY		
SE	10a. STATE	10c. CI	ry, town o	OR LOCA	TION						10d. INSIDE CITY			
a l	Maryland	Monto	gomery		Be	these	da							LIMITS?
AL	10e. STREET AND NUMBER			-	10	. ZIP COD	E	10g. CITIZEN OF			IZEN OF V			
FUNERAL	8615 Irving	gton Av	venue					2081	7			Uni	ted :	States
2	11. MARITAL STATUS 1 Never Merried 2	willian.	12. WAS DECEDENT FORCES? 1 (EVER IN U.S	S. ARMED	13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACI	- American Indian, White, etc.
BY	3 Widowed 4 Divo		IF YES, GIVE WI	R OR DATES	22,310			2X NO			en, enc.)		Speci	
삗		EDENT'S EDUC highest grade		16a	Give kind of	work done i	CCUPATIO	ON ast of working	10	16b. K	ND OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5+)		ille. Do NOT	se retired.)								
ğ	17. FATHER'S NAME (First, M.	Intelle A	5+		Consul	tant			_		Secur			
	Seymour D.		cmark							J. A		Sumame)		
BE	19a. INFORMANT'S NAME (7)		MALK		195 MAII IN	ADDRESS	S /Street s			loute Number,		Chata 7	- C- d-1	
임	Sandra V. S				829 D	orset	t Wa	у, В	Ken.	S'Ca:	lifor	nia	945	
	20a. METHOD OF DISPOSITI 1 Burlet 2 Crematio 4 Donation 8 Other	n 3 🗆 Remo	oval from State	20b. PLA cometery MON	ceand pate , crematory or tgomer	v Čre	emat	oriu	m. Ir	nc.	Bot	haed	> M:	baclura
	21, SIGNATURE OF RUNERAL	SERVICE LIC	ENSE			22.	NAME A	ND ADDRES	SS OF FAC	Rok	ert	A. P	umph	cey Funeral
	· Na	ilE	· Lesse	. M	00803	Wis	scon	sin A	Avenu	le, Be	thes	da.	Marvi	7557 Land 20814
	23. PART i. Enter the di shock, or he	seeses, or c	omplications that list only one caus	coused the	e death. Do	not enter	the mo	de of dy	ing, such	aa cardia	or respi	retory ar	rest,	Approximate
	IMMEDIATE CAUSE (Fin	-1					_	,				,		Interval Between Onset and Death
	disease or condition resulting in death)	+ ,	Ather	oscl	pron	2	Wil	-dic	Va	scul	ur	di	300	R
			DUE TO (OR AS A COP	NSEOUENCE (NF):								
8 0	Sequentially list conditi		DUE TO (D AS A COA	NSEQUENCE (F.								
CERTIFICATION	If any, leading to immed cause. Enter UNDERLY	NG			TOLOGENOL (. ,.								
드	CAUSE (Disease or inju- that initiated events	y 🏅 °	DUE TO (OR AS A CON	NSEQUENCE (F):								-
토	resulting in death) LAS		i											
TI III	PART II. Other aignifica	nt conditions	contribution to d	eath but n	ot requiting	in the un	elo el ulo		shore to f	20-01				
EDICAL	<u> </u>	TO TO TO TO TO	Contributing to c	eetii but ii	ot resuming	m the un	deriyin	g cause g	jiven in i	Part I. 24	PERFOR		246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE
	-										YES 2			OF DEATH?
Σ	DID TOBACCO U	SE CONITE	IDLITE TO CAL	ISE OF D	CATLL	rc 🗆 .	10 F	1 11110	CDTAIN		Jusha			1 YES 2 NO
NA I	25. WAS CASE REFERRED TO		IBUTE TO CAC		LACE OF DEA			UNC	ERTAIN					
잃	EXAMINER?		HOSPITAL:			OTHER	1:							
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF II	JURY	28b. Til	E OF	28c. INJ	URY AT	sidence (28d. DESCR		JURY OC	CURED	
		Pending nvestigation	(Month, Day	(Year)	114	JURY M	1 🔲 1	RK?	NO					
ă I	redident	INJURY — A	it home, ferm,	atreet, facto	ory, offic					nd Numbe	or Rural A	oute Number,		
പ	3 Suicide	Could not be		te, ferm, street, factory, office 28f. LOCATION (Street and Number City or Town, State)										
	=	Could not be letermined	building, a	с. (Specify)										
PLETED	4 Homicide	letermined	building, a		, death occur	ed at the ti	me, data	and place,	and due t	to the cause	a) and men	ner as eta	ted.	
OMPLETED	4 Homicide 29a. CERTIFIER (Check only	FYING PHYSIC	Dullding, a	y knowledge										and manner ea stated.
E COMPLETED	4 Homicide 29a. CERTIFIER (Check only	FYING PHYSIC	Dullding, a	y knowledge				eath occur		lme, date en		due to the	ne cause(a	
H	29a. CERTIFIER (Check only one) 1 CERTIFIER 2 MEDIC	FYING PHYSIC	Dullding, a	y knowledge				eath occur 29c. LICE	ed at the t	ime, date en		due to the	ne cause(a	(Month, Day, Year)
H	29a. CERTIFIER (Check only one) 1 CERTIFIER 2 MEDIC	FYING PHYSIC CAL EXAMINER	MAN: To the best of m	ry knowledge mination end	S/or trweatigati	on, In my o		eath occur 29c. LICE	ed at the t	ime, date en		due to the	e cause(a E SIGNED	(Month, Day, Year)
w II	4 Homleide 29a. CERTIFIER (Check only one) 1 CERT 2 MEDI 29b. SIGNATURE AND TITLS	FYING PHYSIC CAL EXAMINER	MAN: To the best of m	ny knowledge mination end	(tTEM 27) (Type	on, In my o	pinion, d	29c. LICE	NSE NUM	BER	d place, and	29d. DAT	E SIGNED	(Month, Day, Year)
H	29a. CERTIFIER (Check only one) 1 CERTICONE) 2 MEDICONE AND TITLE. 30. NAME AND ADDRESS OF CONTROL OF CONTROL ON CONTROL	FYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	DIAN: To the best of n 1: On the best of n 2: On the best of n 2: COMPLETED CAUSE 32: REGISTRAR	of DEATH ((tTEM 27) (Type	on, In my o	pinion, d	29c. LICE	NSE NUM	BER	d place, and	29d. DAT	E SIGNED	(Month, Dey. Year) L 30,1995



be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ö
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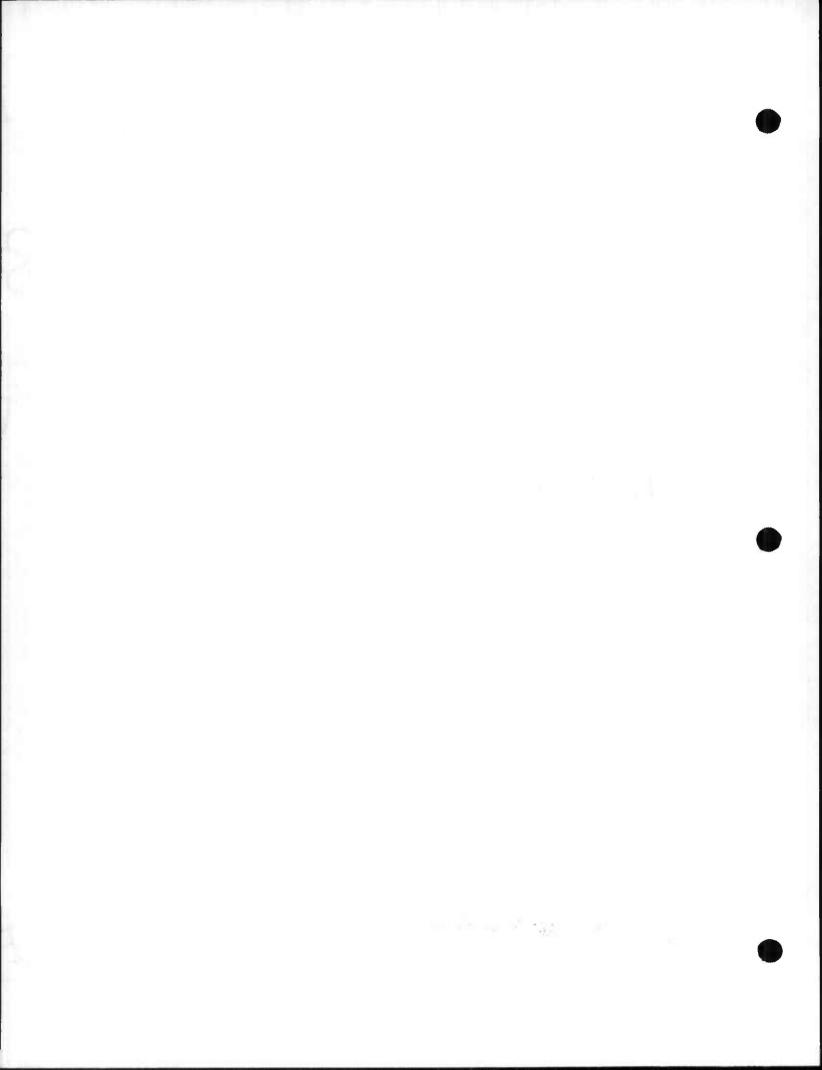
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (1) EM 27) (34

puln

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH HAROLD VICTOR VIOLET 1:00 4 SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. CE (State or Foreign 705-09-1073 1 X M 2 - F DAY8 HOURS MIN. VRS 80 APRIL 19,1915 MARYLAND permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND WASHINGTON HAGERSTOWN 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 1532 DUAL HIGHWAY 21740 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerio Rican, etc.)

1 YES 2 NO Specify: 14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: WHITE 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) detached for College (1-4 or 5+) CARMAN RAILROAD once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 notified at HARLAN VICTOR VIOLET BE EDITH REBECCA PALMER page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ROBERT H. VIOLET 250 N. COLONIAL DR., HAGERSTOWN, MD 21742 pe 20s, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION -- City or Town, Stata DATE must Buriel 2 Cremation 3 Removal from State funeral director, cametery, crametory or other place)
OLD BROWNSVILLE CEMETERY 5/9/95 BROWNSVILLE, MARYLAND 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE-AICENSEE 22. NAME AND ADDRESS OF FACILITY 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME au filled in by the fillen, or removal. Boonsboro, MD 21713 the medical 23. PART i. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failura. List only one ceuse on each line. interval Betwe cremation, or IMMEDIATE CAUSE (Final Onsat and Death disease or condition event, reaulting in death) prior to burial. traumatic CERTIFICATION en signed by the attending physician and of Health and Mental Hygiene prior to bur Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST 10 Injury, PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? shows any 1 - YES 2 - NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item HOSPITAL: 1 YES 2 NO patient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, WITH 1 Natural
2 Accident 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death ΒY 500 Investigation 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28 is 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide item 29a. CERTIFIER TERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL O
De filed within 72 ho
IMPORTANT: If ite THE HOSPITAL O THE FUNERAL D filed within 72 ho 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. SAMAYURGAND TITLE OF GERTIFIER 290-LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) dial



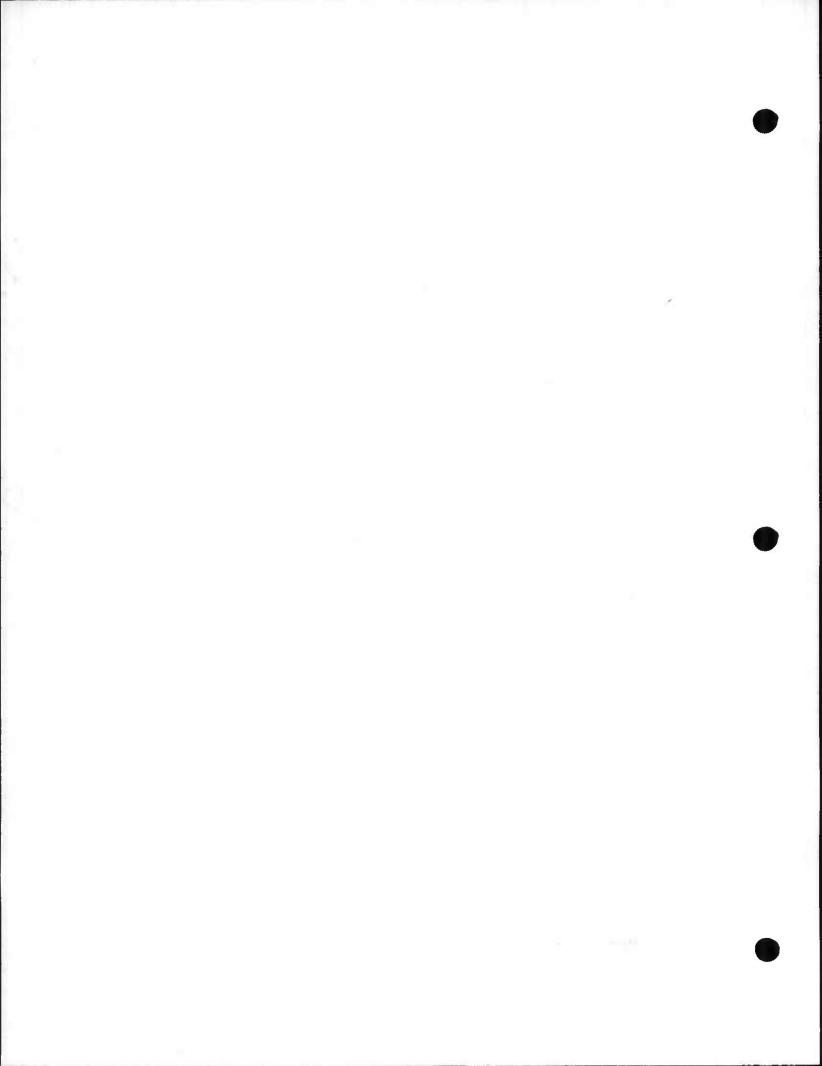
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the modern from a fact of the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the artiending physician and completely filled in by the funeral director, page 5 should be detached for use as the burital-transit nermit Panes	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDI	TO THE FUNERAL DIRECTOR: A	be filed within 72 hours after di	IMPORTANT: If Item 28 is	

1, 2, 3 should

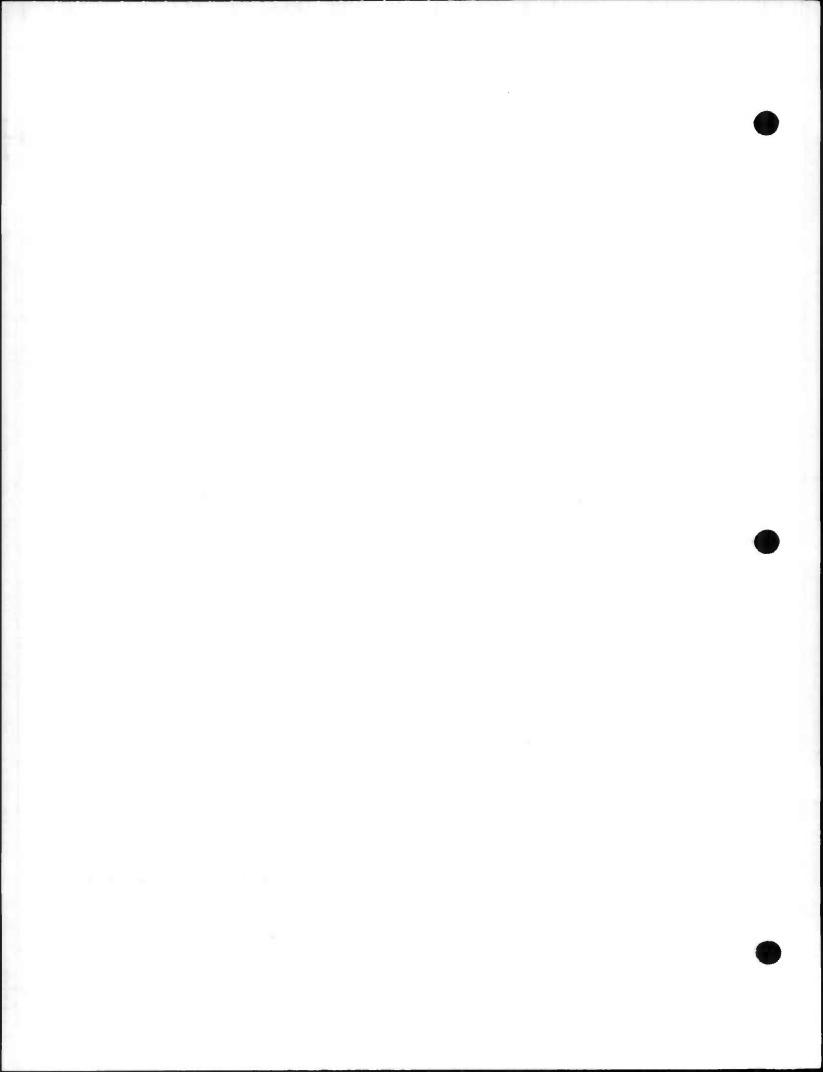
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF HEALTH	AND MEI	NTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)			AIL OI DEAI	-	DATE OF DEATH		3. TIME OF DEATH			
	MA	RY SUE	7	ALENTINO		May 1	1995 YEAR	6:00 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		UNDER 1 YEAR IF UNDER		DATE OF BIRTH	8. BIRTI	HPLACE (State or Foreign			
	577-16-6012	1 □ M 2XXF 7	7 YRS.	NTHS DAYS HOURS	MIN. M	arch 6,	1918 A	labama			
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA										
DIRECTOR	Frederick Heal	th Care Cent	er	Frede	rick		Frede	rick			
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v									
N N				OWN OR LOCATION				10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	ederick	I III.	Airy			10g. CITIZEN OF	1 YES 2 NO			
ER/	7389 Hillside Tu	rn		217			United	See Contract of the Contract o			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECENDENT O	_	RIGIN? (Specify Yes		E — American Indian,			
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, specify Cubar 1 YES 2 NO	n, Maxican, Pu		Blac Spec	K, White, etc.			
ВУ	3 Widowed 4 Divorced						9,00	White			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	18a. DECEDENT'S US (Give kind of work	done during most of working	g	18b. KIND OF BUS	SINESS/INDUSTRY				
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)							
N N	17. FATHER'S NAME (First, Middle, Last)		Personnel	Specialist			ral Gove	rnment			
	Daniel R. Smi	+h			ers name (f)live	First, Middle, Maiden	Surname)				
BE	19a. INFORMANT'S NAME (Type/Print)	CII	19h MAII ING AD	DRESS (Street and Number		Jones					
2	Kenneth A. Valen	tino		Hillside Tu				d 21771			
		201	PLACE AND DATE OF D	ISPOSITION /Name of		DATE 20c 10	CATION — City or To	nun Ctata			
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	netary, crematory or other. altimore N	ational Cen	neterv	5/3/95	Catonsv	ille, Maryla			
	21. SIGNATURE OF FUNERAL SERVICE-LIC			22. NAME AND ADDRES	S OF FACILIT	YStauffe	r Funora	1 Homes, P.A			
		·		8 East Ri							
	23. PART . Enter the diseases, or o	complications that calles	d the death. Do not								
	/ anock, or haart failura.	List only Dne cause on a	ach iina.				iratory arrest,	Approximata interval Batween			
	IMMEDIATE CAUSÉ (Final disease or condition	Anna	that:	Car	5			Onset and Death			
	disease or condition resulting in death) DUE TO (OR KS A CONSEQUENCE OF):										
z											
일	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
S	Cause. Enter UNDERLYING CAUSE (Disease or injury										
#	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):								
CERTIFICATION	Total III daliti) Exor	d									
ALC	PART ii. Other significant condition	s contributing to death b	out not resulting in t	he underlying causa g	ivan in Part			. WERE AUTOPSY FINDINGS			
						t YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
						1 123 2	CALMO	DF DEATH?			
ä	DID TOBACCO USE CONTE	RIBUTE TO CAUSE C	F DEATH YES	□ NO □ UNC	ERTAIN []		1 120 2 110			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (
Sign	1 TES 2 DONO	HOSPITAL: 1 Inpatient 2 ER/Outp		THER: Chursing Home 5 - Res	sidence 8 🗌	Other (Specify)					
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		28d	DESCRIBE HOW I	NJURY OCCURED				
BY	1 Natural 5 Pending 2 Accident Investigation	200000000000000000000000000000000000000		M 1 YES 2	NO						
- 1	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, stree	t, tactory, offica	281.	LOCATION (Street a City or Town, State)	and Number or Rural F	Route Number,			
립	29a. CERTIFIER (Check only one)	CIAN: To the best of my know	ledge, death occurred at	the time, date and place,	and due to the	cause(a) and man	nner an atated,				
	2 MEDICAL EXAMINE	R: On the basis of examinatio	n and/or investigation, in	my opinion, death occurre	d at the time,	data and place, an	d due to the cause(s	n) and manner as stated.			
<u> </u>	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
SE COMPLETED	29b. SIGNATURE AND TITLE OF CERTIFIER	2	_					(mornin, Day, rear)			
BE	(with 1	5. hunn	~1	1	2-18	191	D 5-1	22.7 E. M. 100			
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE		<i>1</i> .			► 5-1	-7)			
BE	30. NAME AND ADDRESS OF PERSON WHO ARTHUR MANALO	o completed cause of de D, M.D. 187	Thomas Jo	1			► 5-1	-7)			
BE	30. NAME AND ADDRESS OF PERSON WHO	o completed cause of de D, M.D. 187	Thomas Jo	<i>1</i> .			► 5-1	-7)			



LL OR ATTENDING PHYSICIAN. The law requires that the death centificate be executed within an analysis of may be retained by the hospital or attending physician.	R: After th	
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	IMPORTANT: If item 28 is marke

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	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND C	/ DEPAI					MENTA	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DAT	E OF DEATH	MY	YEAR	3. TIME OF DEATN
	DEBORAH F. WE								Apr		,199		2:15 A. M
	4. SOCIAL SECURITY NUMBER 577-62-4323	5. SEX	6. AGE (In yrs. I		IF UNDER	1 YEAR	IF UNDE	MIN.	7. DATE	e of BIRTN oth, Day, Year) 23/06		Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give a	1 M 2 X F	89	YRS.							S. Čarolina		
œ	Prince George				OR LOCAT		EATH			JNTY OF DE			
18	RESIDENCE OF DECEDENT	s nost	o. Cent	Ler		Cne	ver	<u>У</u>			Prir	nce (George's
DIRECTOR	D.C.	N/	/A	10c. Ci	10c. CITY, TOWN OR LOCATION Washington							10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 5724 FO	ote St.	,N.E.			10	200				10g. CIT		HAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		NT EVER IN U.S. A 1 YES 2 X WAR OR DATES	ARMED (NO	13. WAS DECENDENT OF NISPANIC Of it yes, specify Cuban, Maxican, Po					Puarto Rican, etc.)			- American Indian, White, etc.
8	15. DECEDENT'S EDUC (Specify only highest grade	CATION COMPRISED	16a. D	ECEDENT'S	USUAL O	CCUPATION	ON		16	b. KIND OF BU	SINESS/IN	DUSTRY	
COMPLETED	(Sine kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5 +) (Give kind of work done during most of working life. Do NOT use retired.)												
MP	12th Examiner U.S. Governm									rnme	ent		
8	17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Tamog Mai Tam								,				
BE	James Walter Fuller Minnie Hur								Humph	rey			
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	Derrick N. Skeeter Same as # 10 above												
20s. METHOD OF DISPOSITION 1X Burisi 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of commettery, crematory or other place) Lincoln Mem. Cem. 4/29/95 Suitlan													
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- ILlnc	oln	Mem	NAME A	em.	4 / Z	CILITY	5 I Su	ıtla	ind, N	1d
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY H. S. Washington & Sons, Inc. 4925 Burroughs Ave., N. E. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, Approximete												
CERTIFICATION	ahock, or heart feliure. List only one ceuse on each line. Interval Between Onset and Death Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): ACUTE Altered Mental Status DUE TO (OR AS A CONSEQUENCE OF): Possible Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF): Possible Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL CI	PERFORMED? 1 TYES 24 TYNO									WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	ATH Y	ES 🗆 1	NO [UNC	ERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEA	TH (Check								
YSI	1 TYES ZYZYNO	1 Impatient 2	ER/Outpetient		4 🗆 Nun		e 5 🗆 R	asidence	8 🗆 Oth	er (Specify)			
ву Рн	27. MANNER OF DEATN 12 Neturel 5 Pending 2 Accident Investigation	(Month, E		28b. TIA	IE OF JURY M		URY AT PRK7 YES 2	□ NO	28d. DE	SCRIBE HOW	INJURY OC	CURED	
8	3 Suicide 6 Could not be 4 Homicide datarmined	26s. PLACE (building,	OF INJURY — At h, etc. (Specify)	iome, farm,	street, fact	ory, offic	•		28f. LO	CATION (Street or Town, State)	and Numbe	r or Rural Ro	oute Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of a	f my knowledge, d	leath occurr Investigation	ed at the ti	ime, data pinion, d	and place	, and due	to the ca	use(a) and ma a and place, ar	nner aa sta nd dua to ti	ited. ha cause(a)	and manner as stated.
BE	200. SIGNAPURE AND TITLE OF CERTIFIE	-m	~~~				29c. LICENSE NUMBER D 31528				29d. DATE SIGNED (Month, Day, Year) April 24, 1995		
10	Margaret Akpan					Rd.	,Che	evei	cly,	Md.	2078	35	
	31. MAY U3 1995	32. REGISTRA	ar's signature										



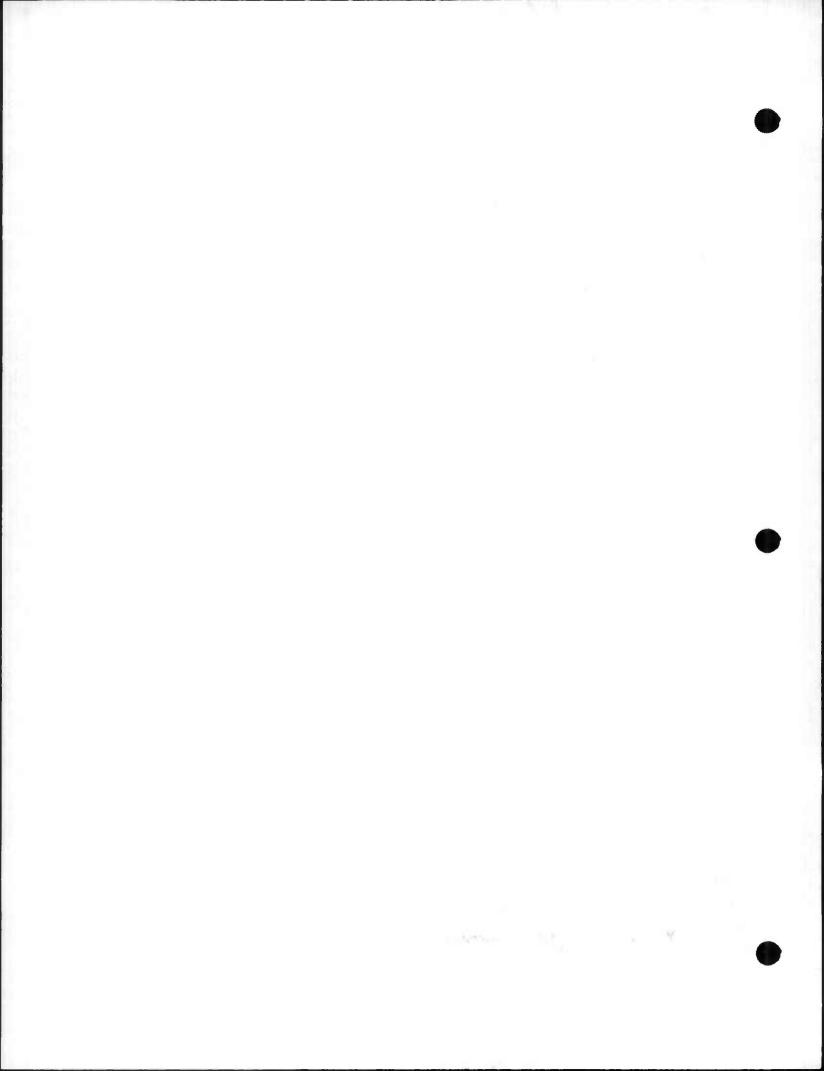
LTIMORE, MARYLAND 21215-0020

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND N	IENTAL HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
		SUSAN WEBB				APRIL 25	, 1995	7:05 A M				
- 8	The state of the s			F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIFT	THPLACE (State or Foreign				
	251-34-8427 9a. FACILITY NAME (If not inatitution, give stree	□ M 2 X F 76	YRS.			Sept 16,	1919 S	outhCarolir				
E		h.		Cheve	R LOCATION OF DEA	NTH	9c. COUNTY OF					
BY FUNERAL DIRECTOR	Prince George C	ounty nos					Prince	e George				
IRE	Maryland Princ	0 (00000	200	TOWN OR LOCAT			10d. INSIDE CITY LIMITS?					
LD	10e. STREET AND NUMBER	e George		t Ple	asant	1 🖄 YES 2 [
ERA	7007 Canyon Dr.			1	20027		USA	WHAT COUNTRY?				
CN	11. MARITAL STATUS 1:	2. WAS OECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENCENT OF HISPANI	C ORIGIN? (Specify Yes	or No.— 14. RAC	DE — American Indian,				
3Y F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES	TES XNO		2 NO Specify:	, Puerto Rican, etc.)		ck, White, atc.				
	16. DECEDENT'S EDUCAT	TION	16a. DECEOENT'S US	1		T		Black				
ETE	(Specify only highest grade cor	mpleted) College (1-4 or 5 +)	(Give kind of wor	k done during mo.	st of working	16b. KINO OF BUS	BINESS/INDUSTRY					
APL	12	Sollege (14 or 5 v)	Homen	Dome	stic							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	E (First, Middle, Malden										
BE	Edgar Darby		Susan	Davis								
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	20a, METHOD OF DISPOSITION	200				shington	,D.C.	20020				
20s. METHOD OF DISPOSITION 1X Burla! 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Pk 4-28-95 Hyattsville, Md.												
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	AT INOTITY 1	22. NAME AN	O ADDRESS OF FACE	411Ken	nady St	- N L				
	De a a	o Mat	$\overline{\alpha}$	Unive	rsal Moi	rtuary	Washing	gton,D.C.				
	23. PART i. Enter the diseases, or com	nplications that caused	the death. Do not					Approximata				
	ahock, or heart fallure. Lia iMMEDIATE CAUSE (Finei	t only one cause on ea	ch ilne.	1	~ · · · \			interval Between Onset and Death				
	disease or condition resulting in death)	Million WECOLKATORY INTO E										
ĺ	OUE TO (OR AS A CONSEQUENCE OF):											
0	Sequentially list conditions, DUE TO OR AS A CONSEQUENCE OF: DUE TO OR AS A CONSEQUENCE OF:											
EAS	if any, leading to immediate cause. Enter UNDERLYING	CTRO	KE	•				>3-46				
Ĕ	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):					1 1 1 1				
CERTIFICATION	resulting in death) LAST	HT	V									
	PART II. Other aignificant conditions of	ontributing to death bu	t not resulting in/	underlying	cause given in P	art i. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS				
PHYSICIAN: MEDICA	Seizure - di	· reposes	DYSO	nag	i pi	PERFOR	MEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
MED	0		0	0		_ 1 YES 2	N°	OF DEATH? 1 ☐ YES 2 ☐ NO				
N	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES		UNCERTAIN	TAN /						
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF DEATH									
IXSI		☐ Inpatlant 2 ☐ ER/Outpa	tient 3 DOA 4		5 Rasidence 8							
	5 Pending	28a. DATE OF INJURY (Month, Day, Year)	286, TIME O	F 28c. INJU Y WOI	RK?	28d. DEŞCRIBE HOW IN	JURY OCCURED					
B	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY -	A home, farm, stre			281. LOCATION (Street a	and Number or Rural Route Number,					
COMPLETED	8 Could not be determined	building, etc. (Spec	7)			City or Town, State)	TO THE OF THE E	riodie Humber,				
LE.	29a. CERTIFIER Check only	N: To the beat of my knowle	doe, death occurred	t the time, data	and place, and due to	the cause(s) and man	ner se stated					
WO		On the basis of examination						s) and manner as stated.				
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	7200	~ \(\)		29c. LICENSE NUMB		29d. DATE SIGNE					
TO B	- 0	20/	M		D-345	725	POC+	25195				
F	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Pr	1000	6 ROA	N-429	OI DA	110				
	31, DATE, FILED (Month, Day, Year)	321 BEGISTRAR'S SIGNAT	INA I CO	100m () (1 NOW	1100	100	16-1-21M				
	MAY UL 1995 Sale	develor hand	-11									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

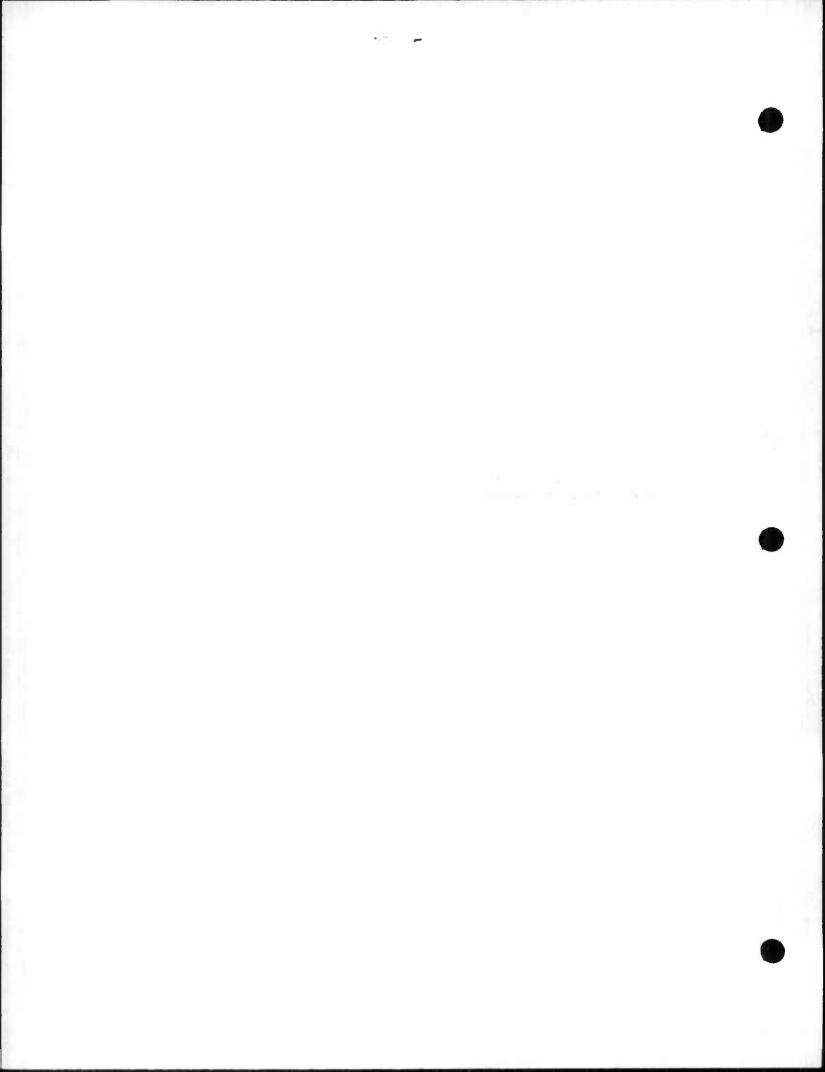
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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

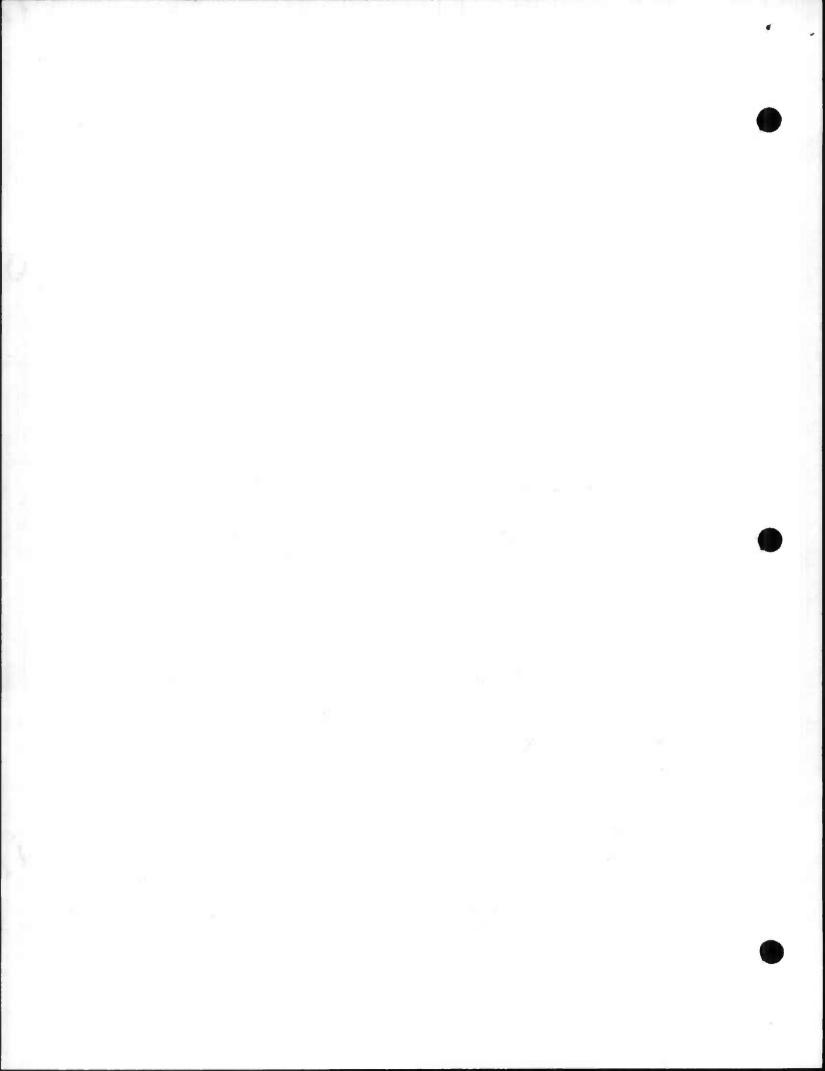
	REGISTRAR		CER	TIFIC	ATE OI	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) ANTHONY		J.		WE	ST	2. DATE MONT MA	of DEATH	6	9 ⁵ 5	3. TIME OF DEATN 8:50A M	
	4. SOCIAL SECURITY NUMBER 208-30-3547 9e. FACILITY NAME (If not institution, give s	1 M 2 F	GE (In yrs. last birt	52 YRS. MONTHS DAYS			Oct	of BIRTH h, Day, Year) ober 2	5,42	Pen	nsylvania	
TOR	PHYSICIANS ME			96.		OR LOCATION OF D			9c. COUN	ARL.		
DIRECTOR	10a, STATE 10b. COUNT		10		WN OR LOC						10d. INSIDE CITY LIMITS?	
	Maryland Cha	rles		LaPlata 101. ZIP CODE					10g. CITIZ	1 YES 2 NO		
FUNERAL	7020 Rose Lan	12. WAS DECEDENT EV	ED IN II C ADMEN	20646 ARMED 13. WAS DECEMBENT OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL OF HISPANIC ORIGINAL CONTROL ORIGINAL					U.S.A.			
B	1 Never Married 2 Married 3 Widowed 4 Divorced	r dates	If yes, specify Cuban, Maxican, Puerto Rican, etc.) I YES 2 NO Specify:					ea or No— 14. RACE — American Indian, Black, Whita, etc. Specify: White				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give ki	5a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY							***************************************	
OMP	12 17. FATHER'S NAME (First, Middle, Last)		Pair	Painter Dept. of the Navy 19. MOTHER'S NAME (First, Middle, Melden Surname)								
BE C	Holly West Helen Jurewiez											
2	19a. INFORMANT'S NAME (Type/Print) Connie West		19b. M/		RESS (Street	and Number or Rural #10	Route Num	ber, City or Town	n, State, Zip (Code)		
	20e. METNOD OF DISPOSITION 1											
	21. SIGNATURE OF FUNERAL SERVICE LIC	1111	100668	y Me	Wil	und address of fa liams F	unei	cal Ho	ome,	P.A	20640	
ATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL	PERFORMED? 1 DYYES 2 NO OH								WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 「NYES 2 「 NO			
AN	DID TOBACCO USE CONTI	RIBUTE TO CAUSE					N 🔲					
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:	26. PLACE OF	ОТ	HER:	ne 5 🗆 Rasidence	8 Othe	or (Specify)				
H.	27. MANNER OF DEATH 1 Netural 5 Pending	28a, DATE OF INJU (Month, Day, Ye	ar)	b. TIME OF	28c. IN	JURY AT ORK?	28d. DES	CRIBE HOW IN				
0 84	2 Accident Investigation 3 Suicide 8 Could not be	5/6/95 28a. PLACE OF INJ building, etc. (URY At home, I	0830 Iarm, street	M 1 1		28f. LOC	ATION (Street a			QOL OF AUTO	
<u> </u>	4 Nomicide detarmined		ROAD				Rout	or Town, State)			Y MD	
COMPLETED	(Check only	CIAN: To the best of my k R: On the bests of examin									and manner se stated,	
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER	might A	10		29c. LICENSE NUMBER O.C.M.E.					DATE SIGNED (Month, Day, Year) MAY 07/95		
	30. NAME AND ADDRESS OF PERSON WHO DONALD G. WRI	GIHT MD 1	DEATH (ITEM 27) 11 PEN	N ST	REET	, BALTI	MORE	E, MAI	RYLAN	ID 2	1201	
	31. DATE FILED (MANY, Day, Year) 1995	To project panels of								-		



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TO THE FOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FINERAL DIRECTOR- After this certificate has been stranding physician and completely by the shortest death and dependent on the purple of the physician and completely by the shortest death and dependent of the physician and completely by the shortest death and dependent of the physician and completely by the shortest death and dependent death death and dependent death and dependent death and dependent death and dependent death and dependent death and dependent death and dependent death and dependent death and dependent death and death and dependent death and dependent death and dependent death and death	be filed within 72 hours after death with the State Dept of Health and Mental Hygher prior to burial, cremation, or removal, page 2 should be as the burial-trainsh permit, rages 1, 2, 3 should like within 72 hours after death with the State Dept of Heim 23 should a should have any injury or other fraumship asked the medical examinar much he motitaled as some
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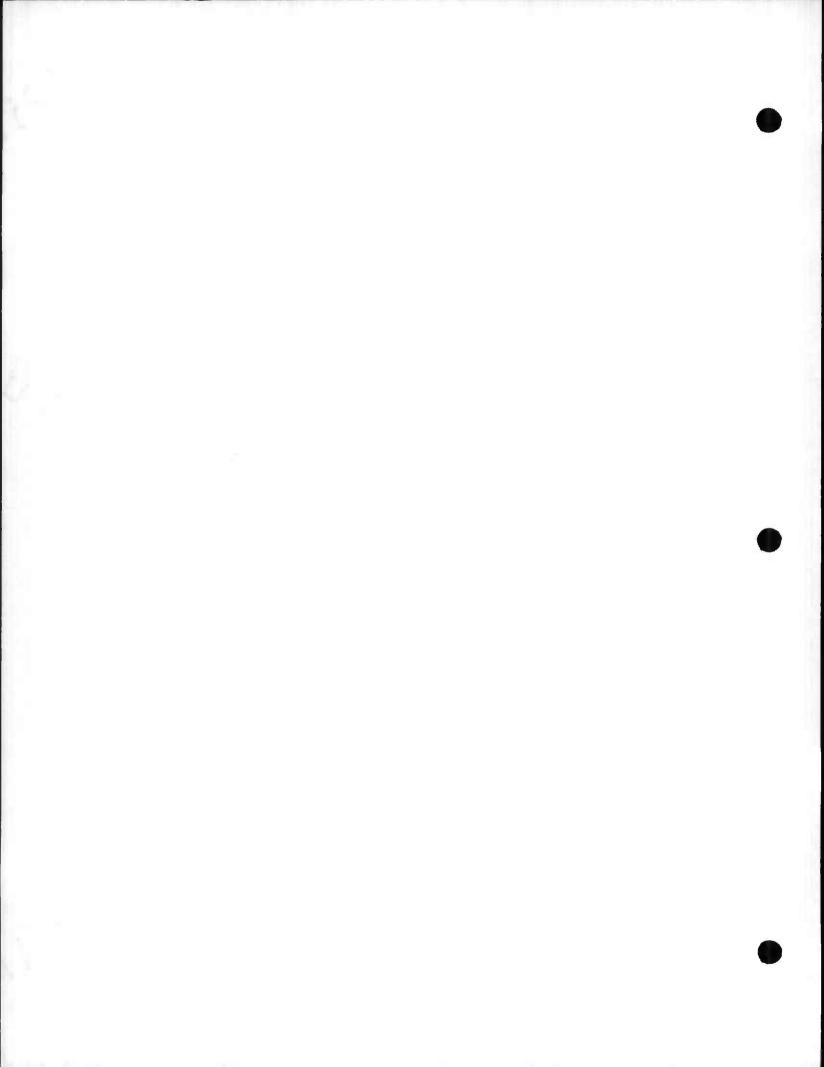
	1 - FOR STATE OF MA	RYLAND / DEPART CERTIFIC	MENT OF HEA	LTH AND ME	NTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Lest) JAMES LAW	RENCE WELSH			DATE OF DEATH	w 10	YEAR 3	TIME OF DEATH		
		AGE (In yrs. last birthday) 73 YRS.	YRS. MONTHS DAYS HOURS MIM.			921	Mary.			
TOR	Laurel Regional Hospital		Laurel	CATION OF DEATH	1	9c. COUNTY OF DEATH Prince George				
DIRECTOR	104. STATE 106. COUNTY Maryland Prince George	10c. CITY,	TOWN OR LOCATION					Dd. INSIDE CITY LIMITS? YES 2 X NO		
FUNERAL	100. STREET AND NUMBER 15617 Bond Mill Road		101. ZIP			10g. CITIZEN OF WHAT COUNTRY? USA				
à	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 Married IF YES, GIVE WAR WO'LD Wa	YES 2 NO OR DATES	If yes, specify	ENT OF HISPANIC (Cuban, Maxican, P NO Specify:	ORIGIN? (Specify Yes warto Ricen, etc.)					
LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during most of	working	16b. KIND OF BUS					
COMPL	Grade 12 17. FATHER'S NAME (First, Middle, Last)	Enginee	18.		First, Middle, Maiden	Surname)	es Gor	vernment		
IO BE	Lawrence Amos Welsh 19a. INFORMANT'S NAME (Type/Print)		DORESS (Street and No	imber or Rural Route		n, State, Zip				
	Flizabeth Welsh 20a. METHOD OF DISPOSITION 1 % Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	206. PLACE AND DATE OF Completery, cremetory of other Eminanuel	DISPOSITION (Name of		DATE 20c. LO					
	21. BIGNATURE OF PINERAL SERVICE LICENSEE	2	22. NAME AND AD Donalds		ral Home,	P.A		-		
	23. PART I. Enter the dispasses or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or haert failure. List only one cause on sach line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE to for AS A CONSEQUENCE OF): 313 Talbott Ave. Laurel, Maryland 20707 Approximate interval Between Onset and Death 5 mins.									
ERIIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							ERE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO		
SICIAN	DID TOBACCO USE CONTRIBUTE TO CAUS 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	E OF DEATH YES 26. PLACE OF DEATH		NCERTAIN [
	1 YES 2 NO 1 Inputant 2 ER 27. MANNER OF DEATH 28e, DATE OF INJ	URY 28b TIME			Other (Specify)	JURY OCC	CURED			
	1 Netural 5 Pending (Month, Day, V 2 Accident Investigation 28a. PLACE OF IN Publisher of the Publisher of	JURY — At home, farm, str	M 1 TYES	2 🗌 NO	LOCATION (Street a			e Number		
	4 Homicide datarmined				City or Town, State)					
	(Check only one) Check only 1 CERTIFYING PHYSICIAN: To the best of my one) MEDICAL EXAMINER: On the bests of examination of examination of the control of							nd manner as stated.		
2 2	29b. SIGNAS (INT. AND SITTLE OF CENTIFIER WHAT ON THE COMMON TO SITTLE OF CENTIFIER ON THE CENTIFIE			LICENSE NUMBER	942	29d. DATE	SIGNED (M	7 1995		
	30. NATIVE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF MALESTAN A	TON MD	847(len	Lane	ai	irel	MD		
	MAY 0 9 1005 July Sta	with the Roll II		J						



the burial-transit permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
JR ATTE	NRECTOF	ours afte	em 28
TAL O	RAL D	12 ha	1 1 m
E HOS	IE FUNE	d within	PITANI
10 1	10	De fil	IMP

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGI			0002			
	1. DECEDENT'S NAME (First, Middle, Last) Ellen	Elizabeth				2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH 12:00 A			
			m yrs. lest birthday)	iruff # UNDER 1 YEAR	IF UNDER 24 HRS.	April	25 19	95				
				MONTHS DAYS	HOURS MIN.	(Month, Day, Year		Country,				
	9e. FACILITY NAME (If not institution, give stre			9b. CITY, TOWN (OR LOCATION OF D	Feb. 17		NEW TY OF DE	Jersey			
B	Randolph Hills Nur	EATT.										
DIRECTOR	RESIDENCE OF DECEDENT	.oing nome			Spring	110	Montgomery					
IRE	10a. STATE 10b. COUNTY			TOWN OR LOCAT				10d. INSIDE CITY LIMITS?				
	Maryland Montgo	mery	Gai	thersbu				1 TES 2 NO				
FUNERAL	8644 Sedley Court			101	ZIP CODE		10g. CITE		HAT COUNTRY?			
JNE		12. WAS DECEDENT EVER IN	II S. ADMED	12 946 050	20879		· · · ·	USA				
	1 Never Married 2 Merried	FORCES? 1 YES	2 XNO	If yes, sp	ecify Cuban, Mexico	an, Puerto Ricen, atc.)	GIN? (Specify Yee or No— 14. RACE — American Black, White, etc.					
ВУ	3 🔀 Widowed 4 🗌 Divorced	is tes, once want on by	ies	1 U YES	2 X NO Specif	y:		Specify	White			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	ISUAL OCCUPATION done during mo	ON at of working	16b. KIND OF	BUSINESS/INO	USTRY					
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	retired.)									
MP	12 17. FATHER'S NAME (First, Middle, Last)		aker		Own							
		140	*		ME (First, Middle, Mail	den Surname)						
BE	19a. INFORMANT'S NAME (Type/Print)	George Stoms Mary E. Cook										
2	198. INFORMANT'S NAME (Type:Print) Lois Utterback 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8644 Sedley Court, Gaithersburg, MD 20879											
	20s. METHOO OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION Normand 1 10 TO ATE 1 20h 10 CATION CONTRACTOR OF THE PROPERTY OF											
	Bethel Methodist Church Cemetery Lewes, Del.											
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE /		22. NAME AF	ID ADDRESS OF FA	CILITY						
	Dimothy!	2) (2		franci	s J. Co	llins Fun Blvd.W.	eral H	ome,	Inc			
	23. PART I. Enter the diseases, or/co	mplications that caused	the death. Do no	t enter the mo	de of dving auc	b se cerdiec or re	SII.S	pr.ML	Approximata			
	23. PART I. Enter the diseases, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one cause on asch line. Approximate interval Between Onset and Death											
	disease or condition								Weeks			
	resulting in death) e. Congestive Heart Failure Due to (or as a consequence of):											
Z	Coronary Heart Disease 4 yr											
CERTIFICATION	Sequentielly list conditions, If any, lsading to immediate OUE TO (OR AS A CONSEQUENCE OF):											
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	DUF TO /OR AS A	CONSEQUENCE OF									
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
CE	d											
AL	PART II. Other significant conditions	contributing to death bu	t not resulting in	the underlying	csuse given in		AN AUTOPSY ORMED?		WERE AUTOPSY FINDINGS			
Old	Pneumonia	• •					2 K NO		COMPLETION OF CAUSE OF DEATH?			
ME	Adrenal Insuff								1 - YES 2 - NO			
N.	DID TOBACCO USE CONTRI				UNCERTAI	N 🔲						
PHYSICIAN: MEDIC		HOSPITAL:	6. PLACE OF DEATH	(Check only one)								
448	1 YES 2 NO	1 Inpatient 2 ER/Outpat	28b. TIME			6 Other (Specify)						
	1 Natural 5 Pending	(Month, Day, Year)	INJU	RY WO	RK?	26d. DESCRIBE HO	W INJURY OCC	URED				
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY -	- At home, ferm, str			281. LOCATION (Size	et and Number	or Aural An	ute Number			
TEL	4 Homicide determined	building, atc. (Specif	(v)			City or Town, St.	nto)					
COMPLETED	29e. CERTIFIER (Check only	AN: To the best of my knowle	dge, death occurred	at the time, date	and place, and due	to the cause/e) and i	nenner es etele					
M		On the basis of examination							and menner ee stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				Month, Day, Year)			
BE	Martin C The	(har			D 0894				26, 1995			
2	36. NAME AND ADDRESS OF PERSON WHO	CONFLETED CAUSE OF DEAT	TH (ITEM 27) (Type, F	Print)	2 007		Ι Λ.	FIEL	20, 1775			
	Martin C. Shargel,	M.D. 3720	Farragut	Ave.,	Kensingt	ton, MD	20895-	2110				
	31. DATE FILED (Month, Day, Year)	1 32 REGISTRAR'S SERVICE										
	APR 28 1995		102.00%									



IORE, MARYLAND 21215-0020

DIVISION OF

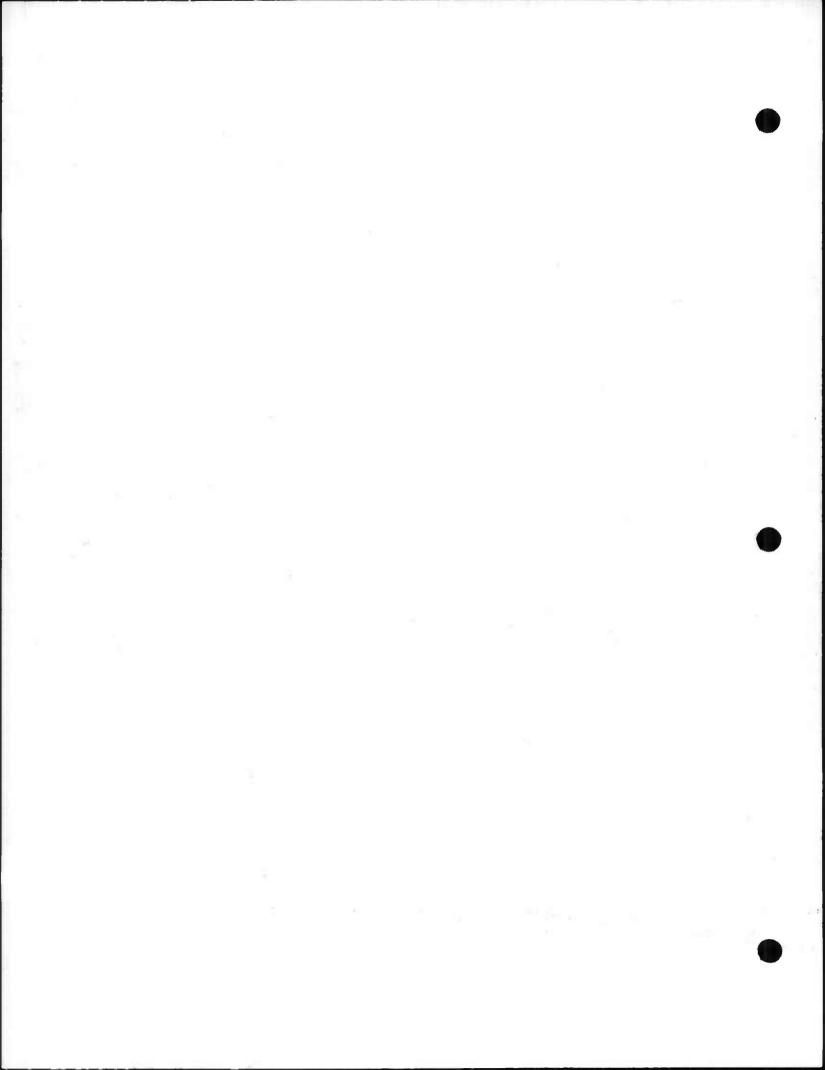
BALLIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Ical examiner must be notified at once.	
Division of VII AL AECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	O BE COMDI ETER BY BUYOLOIMI, MITRION, OTRACIO, TO

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -1. DECEDENT'S NAME (First, Middle, Last)
SHIRLEY
F WOOLPERT

95 15603

	1. DECEDENT'S NAME (First, Middle, Lest) SHIRLEY HAVIOS WOOLPERT 2. DATE OF DEATH MONTH DAY VEAR 2. LATE OF DEATH															
	SHIRLEY	Н	awes			l	NOOL	Pt	KI		100	812	DAY 1	abox	3:15	
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In	n yrs. les	t birthday)	IF UNDER 1 Y	AR	IF UNDER	R 24 HRS.		E OF BIRTH	a.ji	8. BIRTI	HPLACE (State or Foreign	
	215-44-8244	1	1 🗌 M 2 🔯 F	82		YRS.	MONTHS D	NA8	HOURS	MIN.		oth, Day, Year)		Count	ndiana	
. 3	9a. FACILITY NAME (If not in	nstitution, give s	reet and number)				9b. CITY, TO	WN O	R LOCATI	ION OF DE		. 10,		JNTY OF D		
DIRECTOR	Shady Grove	Adven	tist Hos	pita.	1		I	Roc	kvil	lle			1	onto	jomery	
S	10a. STATE	10b. COUNTY	,		_	10c, CIT	Y, TOWN OR L	OCATI	ON						10d. INSIDE CITY	
E	Maryland	Mon	tgomery						0.0						LIMITS?	
	10e. STREET AND NUMBER		egomery			Ь	etheso		ZIP COD)E			100 CT	TIZEN OF 1	1 ☐ YES 2 🔯 NO WHAT COUNTRY?	
FUNERAL	5831 Osce	ola Co	urt							- 316-2	0034					
S	11. MARITAL STATUS	<u> </u>	12. WAS DECEDEN	IT EVER IN	U.S. ARI	MED	13. WAS	DECE				IN? (Specify		United States		
	1 Never Married 2 Married FORCES? 1 YES					2 K NO It yes, specify Cuban, Maxican, Puerto Rican					Rican, etc.)		Blac	k, White, etc.		
BY	3 🔀 Widowed 4 🗌 Divo	proed							21 110	орчену	<i>,</i> .			Spec	White	
COMPLETED	15. DEC (Specify only	EDENT'S EDUC	CATION completed)		(G)	ve kind of v	USUAL OCCU	PATIO	N Lat works	007	16	b. KIND OF E	SUSINESS/IN	DUSTRY		
9	Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of work done during most of working life. Do NOT use retired.)							Unite	ed Sta	ates		
₽ E	5+				Sta	tist	ician					Gove	rnment			
8	17. FATHER'S NAME (First, M					18. MOTHER'S NAME (First, Mide						Middle, Maid	en Sumame)			
BE	Fred C. Hawes Emma Maude McPherson															
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 980.34															
	Anne Echols 13421 64th Terrace, N.E., Kirkland, Washington															
	20a. METHOD OF DISPOSIT	n 3 🗆 Remo	oval from State	20b.1 ceme	PLACE A	ND DATE O	her place	N/Nan	neg 2	9. 1	995	TE 20c.	LOCATION -	City or To	own, State	
4 Donetton 6 Other (Specify) Montgomery Crematorium, Inq. Bethesda, Mar												ryland				
	10 I	A DOL	msee M	La 1		831	Robe	rt	A ADDRE	Pump	ohre	y Fune	eral F	lome/		
	Darbara	10/1/C	"jucken	Hum	rum	ce	Beth	les	da-C	hevy	Ch	ase, l	Inc.	7557	Wisconsin	
	23. PART i. Enter the de	seeses, or o	omplications the	t caused	the de	ath. Do r	ot anter tha	mod	a of dy	ing, suct	h ss cs	rdiac or res	piratory si	reat,	Approximate	
	IMMEDIATE CAUSE (Fin		List Only One Cet	ise on es	cn line.	1		1							Onset and Deat	
	disesse or condition resulting in death)										1 Vaho					
i	DUE TO (OR AS A CONSEQUENCE OF):															
Z	Sequentially list conditions, b. Our Curved My Curved Chromata															
CERTIFICATION	if sny, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):															
2	CAUSE (Disease or injury \$ a															
Ë	that initiated events resulting in death) LAS	т	906 10	(OH AS A	CONSEC	UENCE OF):									
	d															
												24b	WERE AUTOPSY FINDINGS			
MEDICAL												1 TYES	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
Ę I												1 123	2 % 100		OF DEATH? 1 ☐ YES 2 🔀 NO	
	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF	DEA	TH YE	S PI NO	П	UNC	ERTAIN	1				I □ IES 2 IV NO	
X I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)															
Sic	EXAMINER? 1 ☐ YES 2 ☑ NO		HOSPITAL:	ER/Outpat	tlent 3	□ DDA	OTHER: 4 Nursing	Home	5 🗆 Ra	sidence	6 🗆 Oth	er (Specify)				
PHYSICIAN:	27. MANNER OF DEATH		28a, DATE OF (Month, D			28b. TIM	OF 28c	INJU	RY AT			SCRIBE HOW	/ INJURY OC	CURED		
BY		Pending Investigation	(Month, D	ay, roar)	- 1	INJ		WOR YE] NO						
	2 Pulate	Could not be	28e. PLACE O	F INJURY -	At hon	ne, farm, a	treet, factory,	office			28t. LO	CATION (Street	t and Numbe	r or Rural F	Route Number,	
	4 Homicide	determined	Donaing,	mic. (Opecin)	y/						City	or Town, Sta	(e)			
٦	29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the bast of	my knowle	doe des	th occurre	d at the time	deta a	and place	and due	to the se			4-4		
COMPLETED) and manner as stated,	
	296. SIGNATURE AND TITLE				_					ENSE NUM						
H	Pt.	l	1	9					7	49	7/		290, DA1	E SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF OEAT	TH (ITEM	27) (Type.	Print)			(/	. /	,	1, (700	1/110	
	1 Gardons	trifo	mon	15	22	5	SHAD	Y	GV	2016	P	d	Roce	coill	1 25, F95	
	MAY 01 1995 3. TRANS SIGNATURE Reveals															
			-													

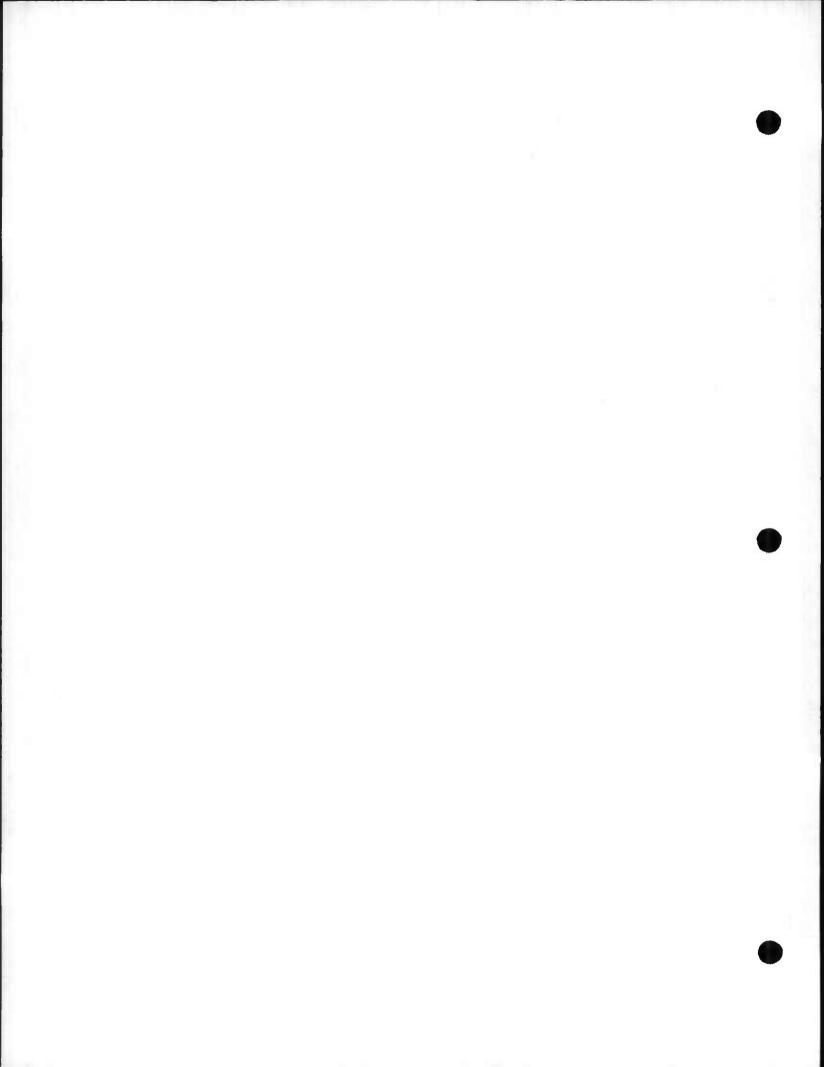


BALTIMORE, MARYLAND 21215-0020

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

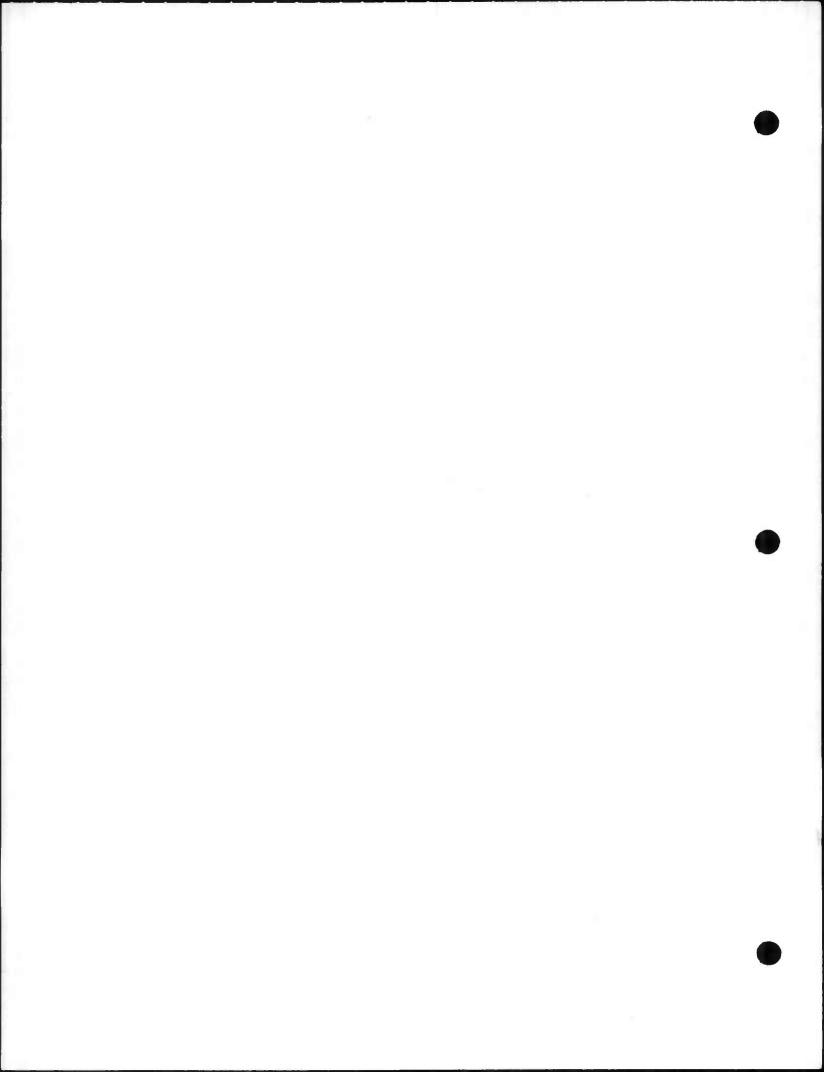
							20	1	5604	
	FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPAR CERTIF	RTMENT OF H		ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	NICEC	WOLF	1-		2. DATE OF DEATH	3. TIME OF DEATH			
	1 (1110)	ANCES	WOLF	<u></u>				YEAR 195	4:40 A M	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8, BIRTHPI Country)	LACE (State or Foreign	
	218-20-0671	1 🗆 M 2 🔀 F	92 YRS.	- CATS		T 1 00 1000			yland	
œ	9e. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF DEAT	Н	9c. COU	NTY OF DEA	ATH	
Ö	Holy Cross Hospi	tal		Silve	r Spring		M	ontgo	mery	
EC.	10a. STATE 10b. COUNT	Y	10c, CIT	Y, TOWN OR LOCAT	TON		IOd. INSIDE CITY			
DIRECTOR	Maryland Mont	gomery		Silver S	pring				LIMITS?	
AL	10s. STREET AND NUMBER	<u> </u>			. ZIP CODE		10g. CITI		IAT COUNTRY?	
FUNERAL	9310 Brookville	Road			20910		Uni	ted S	tates	
5	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 7		13. WAS DEC	ENDENT OF HISPANIC	ORIGIN? (Specify Yes			- American Indian, White, atc.	
BY	1 X Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OF			ecify Cuben, Mexican, I 2 NO Specify:	Puerto Ricen, etc.)		Specify:		
	15. DECEDENT'S EDU	CATION							White	
COMPLETED	(Specify only highest grade	completed)	(Give kind of a	USUAL OCCUPATION Work done during mo	DN st of working	16b. KIND OF BU	SINESS/IND	USTRY		
PL	Elementary/Secondary (0-12)	College (1-4 or 5+)		onsultan	+	De i see	7			
OM	17. FATHER'S NAME (First, Middle, Last)		1 100d C	Onsultan		Dairy/		cultu.	re	
BE C	George Maurice	Wolfe				rances Be				
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural Rou			Code)		
5	Margaret Beall A	ldridge	38 We	st Colle	ge Avenue	. Frostbu	ra. N	Marvl	and 21532	
	20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Rem	oval trom State	20h PLACE AND DATE	DE DISPOSITION /No	me of		LOCATION — City or Town, State			
	4 Donation 8 Other (Specify)		Mount Oliv	other place) May 1, 1995 Frederick, Maryland						
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	O M00831	Robert A. Pumphrey Funeral Home/						
	Janeara p/	KI Weson E	fawten c	Rockv Avenu	ille, Inc	300 Wes	t Mor	ntgom	ery	
	23. PART I. Enter the diseases, of a	complications that cau	sed the deeth. Do n	ot enter the ma	45.444.	TTC/ Hary	-una	200.	30 2003	
		I let anhi ana sausa a	a anala Han	tor eurer rue uto	de of dying, such a	a cardiac or reapi	ratory arr	eat,	Approximata	
	IMMEDIATE CAUSE (Final	List only one ceuse or	n eech line.		de of dying, such a	ia cardiac or reapi	ratory arr	eat,	Approximata interval Between Onset and Death	
		List only one ceuse or	sepsi		de of dying, such a	na cardiac or reapi	ratory arr	eat,	Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	e	n eech line.	Δ	de of dying, such a	es cardiac or respi	ratory arr	eat,	Interval Between	
NO	IMMEDIATE CAUSE (Final disease or condition	eDUE TO (OR A	SEPSU	△	as of dying, such a	a cardiac or reapi	ratory arr	eat,	Interval Between	
ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)	eDUE TO (OR A	sepsi	△	de of dying, such i	na cardiac or reapi	ratory arr	eat,	Interval Between	
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TIMORE, MARYLAND 21215-0020

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.												
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH	3. TIME OF DEATH					
	Anne Emily West	Anne Emily Weston (AKA Anne Weston Caldwell) May 1, 1995									12:12 P M		
	4. SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) if UNDER 1 YEAR if UNDER 24 HRS. 7. DATE OF BIRTH 8. (8. BIRTH	PLACE (State or Foreign		
	220-26-4499	1 D M 2 DxF 8	2 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) April 23, 19	913	M i c	ssouri		
	9a, FACILITY NAME (If not institution, give a		9b. CIT	Y, TOWN C	R LOCATION				ITY OF D				
OB	5480 Wisconsin Avenue #621 Chevy Chase Montgomery												
DIRECTOR	RESIDENCE OF DECEDENT										1		
2		10c. C								10d. INSIDE CITY LIMITS?			
	Maryland Mon	ntgomery		Chev					1 YES 2 X NO				
RA					101	ZIP CODE			10g. CITIZ	ZEN OF W	HAT COUNTRY?		
FUNERAL	5480 Wisconsin A	Avenue, #621				208					d States		
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO		If yes, spe	city Cuban,	Maxican,	ORIGIN? (Specify Yea Puerto Rican, etc.)	or No-	14. RACE Black	— American Indian, , White, aic.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES		1 TYES	2 💢 NO	Specify:			Speci	·		
	15. DECEDENT'S EDU	CATION	18a. DECEDENT	S USUAL O	CCUPATIO	N		16b. KIND OF BUS	INESS/IND	USTRY	White		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		work done	during mos	at of working		County		217 1200			
릴		5+	E	duca	tor			of Educ					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHE	R'S NAM	E (First, Middle, Maiden S	Sumame)				
ш	Burt Horton Wes	ston				Ma	ary	Elizabeth	Tate				
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRES	S (Street a	nd Number or	r Rural Ro	ute Number, City or Town	, State, Zip	Code)	0920-0210		
٦	Robin A. Caldwell	<u> </u>	P.O.E	ox 2	18 (38	313 Ki	ing	William Dr	rive,	Olr	ney, MD		
	20a. METHOD OF DISPOSITION 1 Buriel 2 C Cremation 3 Remo	oval from State	b.PLACE AND DATI						ATION — C				
	4 Donation 5 Other (Specify)	M(ontgomer	y Cre	emato	rium,	, Inc	Beth	. Bethesda, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	M00831	22. Ro	NAME AN	D ADDRESS	OF FACI	hrev Funer	al H	Home/ 7557 Wisconsin			
	Darbara yo M	production	aureni	R Be	ethes	da-Cl	nevy	Cháse, Ir da, Maryla	ic. 7	557	Wisconsin		
\neg	23. PART I. Enter the diseases, of c	complications that cause	d tha death. Do	not entar	the mo	da of dying	, such	as cardiac or respir	atory arre	eat.	Approximata		
	IMMEDIATE CAUSE (Final	List only one cause on	ech line.								Interval Batween Onset and Death		
	disease or condition resulting in death) Metastatic Carcinoma to skin, bones, lung												
	resulting in death)		A CONSEQUENCE OF):							months			
z		Carcimona	of the	Breas	st						years		
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury												
ទ្ធ													
	thet initieted events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE	OF):									
CERTIFICATION	d.												
AL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS												
6 N III								PERFORM 1 YES 2			AVAILABLE PRIOR TO COMPLETION DF CAUSE		
MEDIC								_	VI HO		DF DEATH? 1 ☐ YES 2 🕅 NO		
	DID TOBACCO USE CONTE	RIBUTE TO CAUSE (OF DEATH Y	ES 🔲	NO 🕅	UNCE	RTAIN	- l			,		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE										
š I	1 XYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	petient 3 DOA	OTHER		5 X Resid	dence 8	Other (Specify)					
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TI		28c. INJU	IRY AT		18d. DESCRIBE HOW IN	JURY OCC	URED			
> I	1 Natural 5 Pending 2 Accident Investigation	(Mostri, Day, Tolly		M	1 🗌 Y	ES 2 A	ю						
	3 Suicida 8 Could not be	28a. PLACE OF INJURY building, atc. (Spe	f — At home, term,	street, fact	lory, office		2	181. LOCATION (Street an City or Town, State)	d Number o	or Rural R	oute Number,		
	4 Homicide datarmined							Oily Oi TOWN, State)					
2	29a. CERTIFIER (Check only	CIAN: To the best of my know	riedge, death occur	red at the t	lme, data	ind place, ar	nd due to	the cause(a) and mann	er as atate	d.			
COMPLE		R: On the basis of examination									and menner as stated.		
w II	201. SONATURE AND TITLE OF CERTIFIER					29c. LICENS	SE NUMB	ER	29d. DATE	SIGNED	(Month, Day, Year)		
ם מ	Jestal An	such m	D			DI	121	97)	> c	-1,	195		
2	30. NAME AND ADDRESS OF PERLON WIN	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typ	e, Print)		7	101			7	11,		
	Israel Spector,	M.D. 12001 I	errara .	Avenu	ie, W	heato	n, l	4D 20906					
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGN	IATURE										
	MAY 04 1995	Julia Daveles	Mardall										





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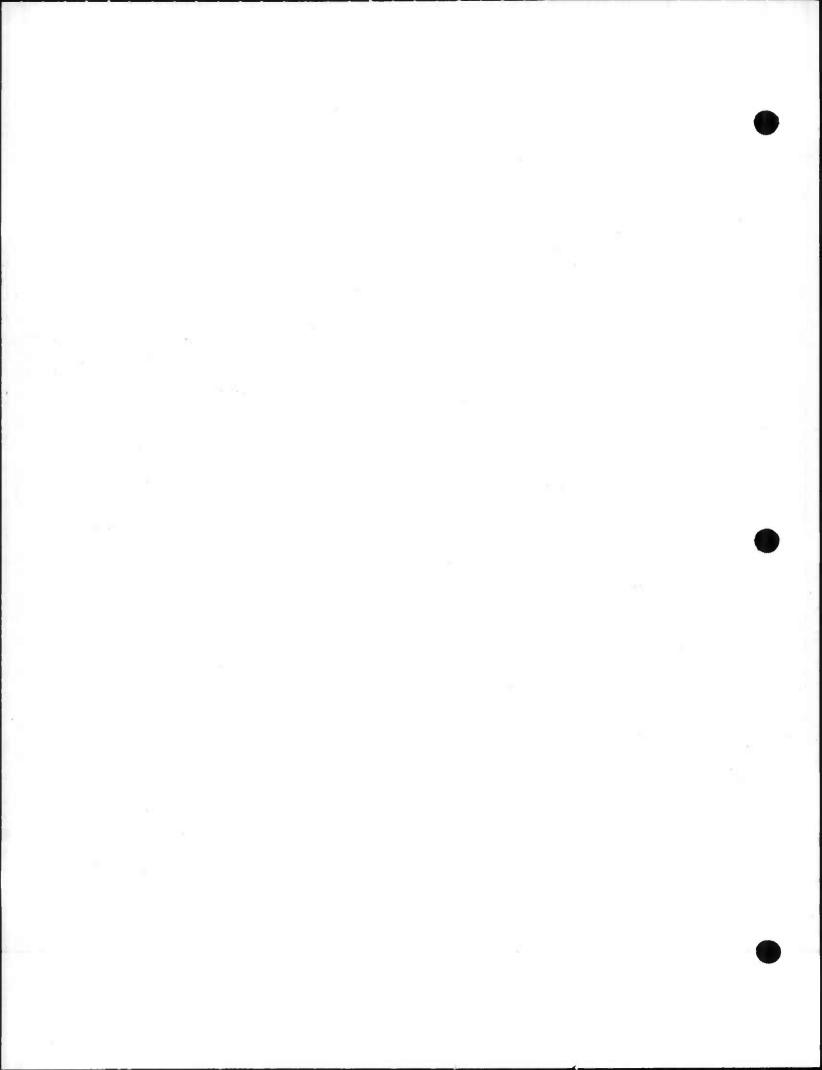
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Charles Larry Whieldon May 2, 1995 1:15 PM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Ybar) 8. BIRTHPLACE (State or Foreign Country) 1√X M 2 □ F DAYS HOURS YRS. 248-64-5540 51 Aug. 14, 1943 South Carolina permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2511 Campbell Place Kensington Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery 1 TES XXXNO Kensington FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? use as the burial-transit 2511 Campbell Place 20895 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 X Never Merried 2 Merried 1 TYES 2 NO BY Specify: 3 Widowed 4 Divorced Specify: White ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Consultant Management 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) BE Joe E. Whieldon Grace Harrington funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 George Thomas Beall Campbell Place, Kensington, Maryland 20895 9 20e. METHOD OF DISPOSITION
1 □ Burlet 2 ☑ Cremation 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Crematorium, I must 1 Burlel 2 Cycremation 3 Removal from State
4 Donation 5 Other (Specify) 1995 Montgomery Inc. Bethesda. examiner 20 AME AND ADDRESS OF FACILITY OF TUNE TAIL HOME BETHESDA-Chevy Chase, Thc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 TI. SIGNATURE OF FUNERAL SERVICE OCENIE M00846 n and completely filled in by the to bunal, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Ret IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition Complications of Aquired Immune Deficiency Syndrome event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate physician prior cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p reaulting in death) LAST 6 PART ii. Other algnificant conditions contributing to deeth but not reaulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL and t shows any signed Health a 1 TYES 2 1 NO OF DEATH? 1 YES 2 X NO t, of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate b HOSPITAL: OTHER: 1 TES 2X NO 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 54 Residence 8 ☐ Other (Specify) ö 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked, with 1 K Netural 6 Pending 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) -00 COMPLETED 6 Could not be DIRECTOR: hours after 4 Homicide determined 29e. CERTIFIER 1 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner es stated. (Check only one) TO THE FUNERAL TO THE FUNERAL DE filed within 72 h 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, desth occured at the time, date end place, end due to the cause(e) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) BE 40 AP8959162 95 031 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D., 2112 F Street, NW, #603, Washington, D.C. 20037-2724

Michael C. Pistole,

32 REGISTRAR'S SIGNATURE SALL

31. DATE FILEO (Month, Day, Year)
MAY 04 1995

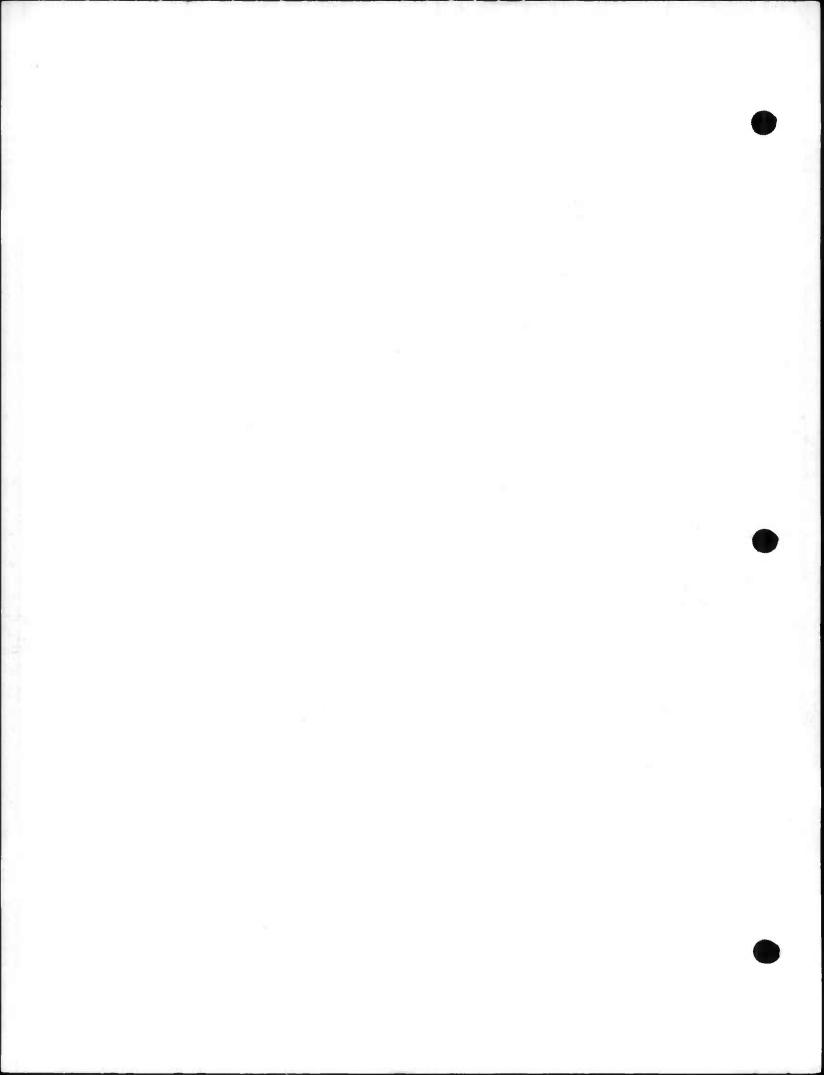


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR				CERTIF	ICATE	OF	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, MI	iddle, Lest)								OF DEATH			3. TIME OF DEATH
		l' I	Doroth	y Thomps	on Wa	aibel				May		199	95	5:27 a M
4		4. SOCIAL SECURITY NUMBER				rs. lest birthday)	IF UNDER 1 Y	/EAR	IF UNDER 24 HRS.		OF BIRTH	1	A. BUSTHE	LACE (State or Foreign
		218-03-8510		1 M 2 F	72	YRS.		AYS	HOURS MIN.	(Mont	h, Day, Year)	1923	Country)	
pino		9a. FACILITY NAME (If not institu	ution alve stree	of and number)	72		ah CITY TY	OWAL OF	R LOCATION OF DE		CII 23,		TY OF DE	aryland
3 should	Œ	Residence:			d		90. GITI, 10					96. COUR		
2,	DIRECTOR	RESIDENCE OF DECE		Thei Mos	id			PO.	rt Depos	11				ecil
es 1	🖺		Db. COUNTY			toc. CIT	Y, TOWN OR	LOCATI	ION					tod. INSIDE CITY
28	뜽	Maryland	Ce	cil				Po	rt Depos	it				LIMITS?
imit.		10e. STREET AND NUMBER						_	ZIP CODE			100 CITE		AT COUNTRY?
	2	180 Waibel H	Road					101.	219	Ω/i		log. Ciri.	U.S	
physician. burial-transit permit. Pages 1, 2,	FUNERAL	11. MARITAL STATUS		12. WAS DECEDENT	EVER MIN	0.40400								
physician. burial-tran	립	1 Never Merried 2 Me	rried	FORCES? 1	YES :	2 K X40			ENDENT OF HISPAN offy Cuban, Maxica			or No-	14. RACE - Block,	- American Indian, White, atc.
the b	B	3 Widowed 4 Divorce	d	IF YES, GIVE W	R OR DATE	S	1 [YES	2 XNO Specify	<i>'</i> :			Specify	White
the hospital or attending detached for use as the once.	ED		ENT'S EDUCA	TION	14	Se. DECEDENT'S	Heliai occi	IDATIO:	AI.	1 401	. KINO OF BUS			willte
or at		(Specify only hi	ghest grade co	mpleted)		(Give kind of a	vork done duri	ing mos	at of working					rsing Home
d for	2	Twelve Year		College (1-4 or 5+)	1		tetic	Λ :	do					9
the host detache	COMPLET	17. FATHER'S NAME (First, Middl				DIE	reric	AIC			ising		магу	Tand
by the	- 1			ose The - man		C			18. MOTHER'S NAI					
to be	핆			er Thomp	son,						Elizab			n
5 should b	2	19a, INFORMANT'S NAME (Type							nd Number or Rural F					
y be rage 5		Russell Willi		rbeī		839 W	indy M	leac	low Circl	le, I	DeSoto,	Tex	as i	75115
ious after death. Page 6 may be retained by the hospital or attending d in by the funeral director, page 5 should be detached for use as the or removal. medical examiner must be notified at once.		20a. METHOD OF DISPOSITION TXXBurial 2 Cremation		ni from Stata		ACE AND DATE		ON (Ner	me of	OAT	E 20c. LOC	CATION -	City or Tow	n, Stata
ge 6 irecti		4 Donation 5 Dother (Sp			Wes	st Nott	inghan		emetery		/95 C	olora	. Ma	rvland
nine	iner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
death. Pag funeral dir I. examiner		Lee A. Patterson & Son Funeral Home												
n by the removal.		Perryville, Maryland 21903												
d in by the or remove		23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Between												
		iMMEDIATE CAUSE (Final disease or condition		4.0										Onset and Death
y te		reaulting in deeth) e. Un Known												
executed within and completely to burial, crematic event, t				DUE TO (OR AS A CO	ONSEQUENCE O	F):							
at pa	N	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):												
be existen a sum	CERTIFICATION	if any, leading to immedia cause. Enter UNDERLYING	ite	DUE TO (OR AS A CO	ONSEQUENCE OF	F):							
	2	CAUSE (Disease or Injury	c.,	DUE 70 /										
nding phy Hygiene g or other	Ē	that initiated evente resulting in death) LAST		DOE TO (OH AS A CO	ONSEQUENCE OF	F):							
death certification attending parties into the state of t	15		d											
y the atternd Mental		PART ii. Other eignificant	conditiona	contributing to	death but	not reaulting	In the unde	riving	ceuse given in	Pert i.	24a, WAS AN	ALITOPSY	24h 1	WERE AUTOPSY FINDINGS
that the ed by the and any In	EDICAL							,	•		PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
uires that is signed Health a DWS am)	ā									-	1 TES 2	NO		DF DEATH?
w requires been sign pt. of Heal	Σ	DID TOPACCO	LICE CC	ALTOIDLITE	TO 6	ALICE OF	DEATH	>/5		/			1	1 TYES 2 NO
has be Dept.	z	DID TOBACCO		NIKIBUTE	10 0	AUSE OF	DEATH	YE	S NO					
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires THE FUNERAL DIRECTOR: After this certificate has been sign filed within 72 hours after death with the State Dept. of Healt PORTANT: If Hem 28 is marked, or Hem 23 shows:	PHYSICIAN:	25. WAS CASE REFERRED TO M EXAMINER?		HOSPITAL:			OTHER:	28. PL/	ACE OF DEATH (Che	ock only or	ne)			
SICIAN: The certificate that the State d, or item	YSI	1 YES 2 NO		☐ Inpatient 2 ☐	ER/Outpatio	ent 3 🗆 DOA		g Horne	5 Residence	8 🗆 Othe	er (Specify)			
PHYSIC this ce with th	H	27. MANNER OF OEATH		28a. DATE OF I (Month, Da		28b. TIM	E OF 28 URY	Ic. INJU		28d. OE	SCRIBE HOW IN	JURY OCC	URED	
NG PHYS fter this cath with marked	ВУ		nding estigation				M	1 🗌 Y	ES 2 NO					
L OR ATTENDING F DIRECTOR: After hours after death item 28 is mar	ED	3 Suicide 8 Co	uld not be	28a. PLACE OF building, a	INJURY — tc. (Specify)	At home, farm,	street, factory	, office			ATION (Street a	nd Number	or Rural Ro	ute Number,
ATTE CTO S afte		4 Homicide det	ermined		, , , , , , , , , , , , , , , , , , , ,					Ony	or lown, state)			
OR A DIREC hours	COMPLET	29a. CERTIFIER 1 CERTIFY	ING PHYSICIA	AN: To the best of r	ny knowlede	ne, death occum	ed at the time	data	and place, and due	to the cou	use(a) and man			
HAL PAL TZ	M													and manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	ဗ													
THE THE SOR	H	296. SIGNATURE AND TITLE OF	CERTIFIER	1.	1			- 1	29c. LICENSE NUM	HBER		29d. DATE	SIGNED (Month, Day, Year)
5 5 3 X	0	COSONN	<u>0, V</u>	relation	DR	-mo			D4437	3			5/5	145
	-	30. NAME AND ACORESS OF PI	EHSON WHO	COMPLETED CAUSI	OF DEATH	(ITEM 27) (Type	Print)	,	·	CI	A 1			
			dNER	Jr.	101	COLONIA	2/ N	av	Risin	1 54	W. M.	021	111	
		31. DATE FILED (Month, Day, Yea	(1)	32. REGISTRAF	_			1)	,	/			
		MAY 0 8 199	5 Ju	la d'Evales	4 Rand	all		/						



BALTIMORE, MARYLAND 21215-0020	e nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	te medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H			YGIENE EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) HAVEN EDWA					2. DATE OF D MONTH	EATN DAY	YEAR 3. TIME OF DEATN			
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		BIRTHPLACE (State or Foreign			
	230–24–2146 De. FACILITY NAME (If not institution, give	XXM 2 F 6	8 YRS.	MONTHS DAYS	HOURS MIN.	1-26	26 VIRGINA				
DIRECTOR	24842 PEN MAR			CASC		AIR		9c. COUNTY OF DEATH WASHINGTON CO.			
RE(10a. STATE 10b. COUNT	Y	10c. CITY	TOWN OR LOCAL	TION			10d. INSIDE CITY			
	MARYLAND WAS	HINGTON CO.		CASCAD	E . ZIP CODE	10a CITIZI	1 YES 2 X NO				
ER/	24842 PEN MAR	ROAD			21719			U.S.A.			
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Sp	ecify Yes or No- 1	4. RACE — American Indian,			
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, sp	ecity Cuben, Mexicar 2 NO Specify	n, Puerto Rican,	etc.)	Black, White, atc. Specify:			
		WWII & K						WHITE			
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	16e. DECEDENT'S L	ork done during mo	ON st of working	16b. KINC	OF BUSINESS/INDU	STRY			
J.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use								
ME	7TH 17. FATHER'S NAME (First, Middle, Last)		MECHAI	ATC				AL GOVERMENT			
		OOD			18. MOTHER'S NAI	NE (First, Middle, IE MAI		N			
H	19e. INFORMANT'S NAME (Type/Print)	ООБ	105 444 110	DDDCCC (C							
5	MARIE WOOD						DE, MD.				
	20s. METHOD OF DISPOSITION	201									
	20e. METHOD OF DISPOSITION Let Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETHEL CHURCH CEM. 5/10/95 CASCADE, MD.										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE PAUL T. LOCHSTAMPFOR ²² . NAME AND ADDRESS OF FACILITY										
	SNIDER-LOCHSTAMPFOR F.H. INC. 48 S. CHURCH ST WAYNESBORO, PA. 17268										
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory screet, Approximate										
	IMMEDIATE CAUSE (Finel										
- I	disease or condition resulting in death)	· Metast	zde No.	a-smal	1 Cell 6	1	Conser	uncer 3 month			
	resulting in death) s. Metastata Non-small Cell Lung Concer 3 months. Due to (or as a consequence of):										
NO	Sequentially list conditions, Dus TO (OR AS A COMPSQUISINGS OF).										
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):										
임	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):										
F	resulting in death) LAST										
8	d										
PHYSICIAN: MEDICAL	PART II. Other algnificent condition	na contributing to deeth b	out not resulting in	the underlying	ceuse given in i	Port I. 24a.	24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ă							YES 2 HO	COMPLETION OF CAUSE DF DEATH?			
M						_		1 _ YES 2 _ NO			
ä											
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTMES: OTMES:										
YSI	1 TES 2 THO	1 Inpatient 2 ER/Outp		OTHER: Nursing Hom	e 5 Aesidence	Other (Spec	offy)				
F	27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE							RED			
BY	1 Flatural 5 Pending 2 Accident Investigation										
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE DF INJURY building, etc. (Spec	— At home, term, str clfy)	reet, factory, office		28f. LOCATION City or Tow	(Street end Number or n, State)	Rural Route Number,			
	M. OFFICIE										
COMPLETED	(Check only	ICIAN: To the best of my know ER: On the basis of examination						:Suse(s) end manner es stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUM						
8	Michael 1	melouse	Am.	0.	041			SIGNED (Month, Dey, Year)			
임	30. NAME AND ADDRESS OF PERSON WH				~ //	66 /		0'7(
	DR.MICHAEL MCC	ORMICK, 17	33 HOWE		, HAGER	STOWN	, MD.				
	31. DATE FILED (MONTH, Day, Year)	Li dieserantin	TIME								

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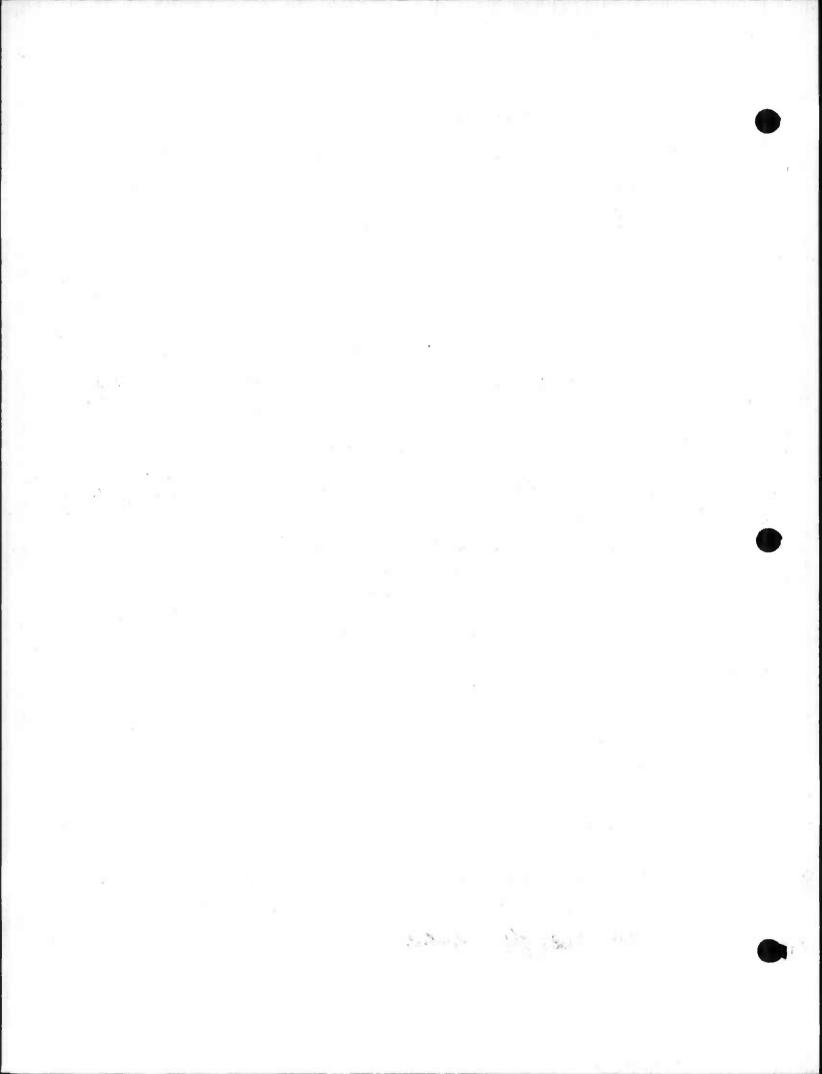
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after, death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use		
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NG P	fter th	eath v	mark
END	DR: A	ter d	8 15
R AT	RECT	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND) / DEPARTMENT	OF HEALT	H AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEA	HT		REG. NO.

1 - STATE REGISTRAR	STATE OF MARYL	CERTIF	ICATE (OF DEATH		REG. NO.				
	WARRENFELTZ				2. DATE OF APRI		1995	3. TIME OF DEATH 5:55PM		
4. SOCIAL SECURITY NUMBER 219-20-4795	1 M 2 X F	(In yrs. last birthday) 94 YRS.		HOURS MIN.	7. DATE OF (Morth, D JULY	BIRTH 11,190	00 Mã	THPLACE (State or Foreign rity) aryland		
90. FACILITY NAME (II not institution, gived Ravenwood Luther Residence of Decement				WN OR LOCATION OF D	EATN		Wash	ington		
	ashington	10c. CiT	v, town or L Hager	stown				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
100. STREET AND NUMBER 1183 Luther D			21740			U.S.	WHAT COUNTRY?			
tt. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 Tyes IF YES, GIVE WAR OR D	2 X NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:					CE — American Indian, ack, White, etc. ecity: White		
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of a life. Do NOT us Homem	work done durin se retired.)	PATION g most of working	1	WIT h	OM C			
	ster Groh				nora		1	/oung		
196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 16544 Tammany Lane, Williamsport, Md. 21795								1795		
20e. METHOD OF DISPOSITION 1 💢 Burlel 2 🗆 Cremetion 3 🗆 Ri 4 🗆 Donetion 5 🗀 Other (Specify)	1 M Burlel 2 Cremetion 3 Removal from State 4 Donetton 5 Other (Specify) Rest of Haver Cemetery 05-03-95 Hagerstown, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew K. Coffman Funeral Home 40 East Antietam St., Hagerstown										
23. PART I. Enter the diseases, of shock, or heart feilur iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	e. List only one cause on e	each ilne.		mode of dying, sur		c or respin	atory errest,	Approximate interval Between Onset and Dea		
Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF)									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUT PERFORMET 1 YES 2						AED?	7 AVAILABLE PRIOR TO COMPLETION OF CAUSE			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 LINE 1 Inpettent 2 ER/Ouipstient 3 DOA 4 Withing Name 5 Residence 6 Other (Specify)										
1 Inpetient 2 ER/Oulpetient 3 DOA 4 Chrorsing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. Time OF INJURY WORK? 1 YES 2 NO 28b. Time OF INJURY WORK? 1 YES 2 NO 28b. Time OF INJURY WORK? 1 YES 2 NO 28b. Time OF INJURY WORK? 1 YES 2 NO										
3 Suicide 4 Nomicide 6 ACould not be determined 289. PLACE OF INJURY — At home, farm, straal, lactory, offica building, etc. (Specify) 289. PLACE OF INJURY — At home, farm, straal, lactory, offica City or Town, Street and Number or Rural Rou City or Town, Street)							l Route Number,			
one)	YSICIAN: To the best of my know							e(a) and menner as stated.		
296. SIGNATURE AND TITLE OF CERTIF	Clean m	(4)		29c LICENSE NU	MBER		29d. DATE SIGNI	(Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON	WNO COMPLETED CAUSE OF DE	EATN (ITEM 27) Type	Print) A	20, 1 400	na 1	3/2	10	7. V		
// // /// /.	178/11	100	10/10	14 Jour	10	211	40			



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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1tems6€7 g 723 5 3	1 95 per F H	dk								95		5610
	1 - STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	OF H	EALTH A	AND I	MENTAL	HYGIEN REG. NO.	E		
	1. OECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
	JOHN EMIL WALKER May							9		995	10:12 aM		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER 2	24 HRS.					IPLACE (State or Foreign
	575-18-4996	1 🔀 M 2 🗆 F	MONTHS DAME LINE				May	BIRTH Day, Ybar) 1	924	Countr	CA		
	9e. FACILITY NAME (If not institution, give	10		9b. CITY,	TOWN 0	R LOCATIO	N OF DE		00/ 1		NTY OF O		
E E	Malcolm Grow	cal Con	tor	δαΛ	TOT-70	s Air	Eor	nac D					
DIRECTOR	RESIDENCE OF DECEDENT	cai cai	CCT	Alic	TEW	2 HII	FOI	rce E	ase	PE	ruce	Georges	
H	10e. STATE 10b. COUNT	-		10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY LIMITS?
	MD Ca			Sund	erla	and						1 TYES 2 NO	
\¥	10e. STREET AND NUMBER					101.	ZIP CODE				10g. CIT	ZEN OF V	VHAT COUNTRY?
FUNERAL	6785 Old Solom	ons Island	d Road,	N			20	689				USA	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED						(Specify Yes	or No-	14. RACE	— American Indian,
₽	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				an, Puerto Rican, etc.) fy:				Specify:		
	15. OECEDENT'S EDU	WW II Ko											white
1 3	(Specify only highest grade	e completed)	(G	CEDENT'S Ive kind of a Do NOT us	vork done d	CUPATIO	N st of working	,	16b,	KIND OF BUS	SINESS/IND	USTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)			ef (D 71			,,	C N			
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)			CII	er (E-/)				.S. Na	_		
	John Andrew Wall	kor								ddle, Maiden	Surname)	77	1.1.1
BE	19e. INFORMANT'S NAME (Type/Print)	/CT	101	MAILING	ADDRESS	(Street or		thil		r, City or Town			ething
2	Hazel L. Walker						Sund						
	20a. METHOD OF DISPOSITION		20b. PLACE					der 1	DATE.		20689 CATION —		
	120 Burlet 2 Cremetion 3 Rem	ioval from State	Mary 1					5_1			ltenh		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1			_	D ADDRESS			Tale.	L CEIII	icili,	PIL
	1 1	// /											
	Lan	Jus	<u> </u>		R	ausc	h Fu	nera	al Ho	ne, P	A Ow	ings	, MD 20736
	23 PART I. Enter the disentes, or shock, or heart failure.	List only one caus	eused the de on each line	eth. Do r	ot enter i	the mod	de of dyin	g, such	as cardi	ac or respi	ratory arr	est,	Approximate Interval Between
	The state of the s									Onset and Death			
	resulting in death)	. MYOCARD											
	DUE TO (OR AS A CONSEQUENCE OF): A DD LLYTTID T A												
ERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
AT	if any, leading to immediate cause. Enter UNDERLYING												
E S	CAUSE (Disease or Injury that initiated events	c. CARDIOP	OR AS A CONSEC										
E	resulting in death) LAST	.=			,								
CE		d											
A.	PART II. Other eignificant condition	e contributing to d	leeth but not n	eeuiting	n the und	deriying	ceuse giv	ven In I	Part t.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
12									_	1 TES 2			AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL													1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEA	TH YE	S 🗆 N	10 🗆	UNCE	RTAIN					
 	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	'H (Check or	nly one)							
Sic	1 VES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		5 🗆 Resi	Idence (5 🗆 Other	(Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF III (Month, Day	NJURY (Year)	26b. TIM	E OF	28c. INJU	JRY AT		26d. DESC	RIBE HOW IN	JURY OCC	URED	
BY	1 Natural 5 Pending 2 Accident Investigation				м		ES 2 [NO					
	3 Suitcide 8 Could not be	26e. PLACE OF building, or	INJURY — At hor	ma, ferm, s	treet, facto	ry, office			28t, LOCAT	ION (Street e	nd Number	or Rural A	oute Number,
Suitable 6 Could not be determined 25t. Location City or for City							iowii, diele)						
4	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of m	ny knowledge, de:	ath occum	d at the tin	ne, date d	end place, a	and due t	to the caus	e(s) end man	ner as state	ed.	
OM	2 MEDICAL EXAMINE	R: On the basis of exa	mination end/or i	nvestigatio	n, in my op	inion, de	eth occured	d at the t	time, date a	nd place, end	due to th	e ceuse(e)	and manner ee stated.
EC	286. SIGHAYURE AND TITLE OF CENTIFIE					Т	29c. LICEN						(Month, Day, Year)
m	HILE HOU	lu-					14	()	34		D 6) 0.4	119
6	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE	OF DEATH (ITEN	1 27) (Type,	Print)	Mal	201=	Cman	~ TTC 4	E M - 2	-/	0 1	912
П	HENRY E HOLLOWA					ral (COTI	GIOV	W USA	F Med	ıcal	Cent	er



HENRY

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31. DATE FILED (Month, Day, Year)
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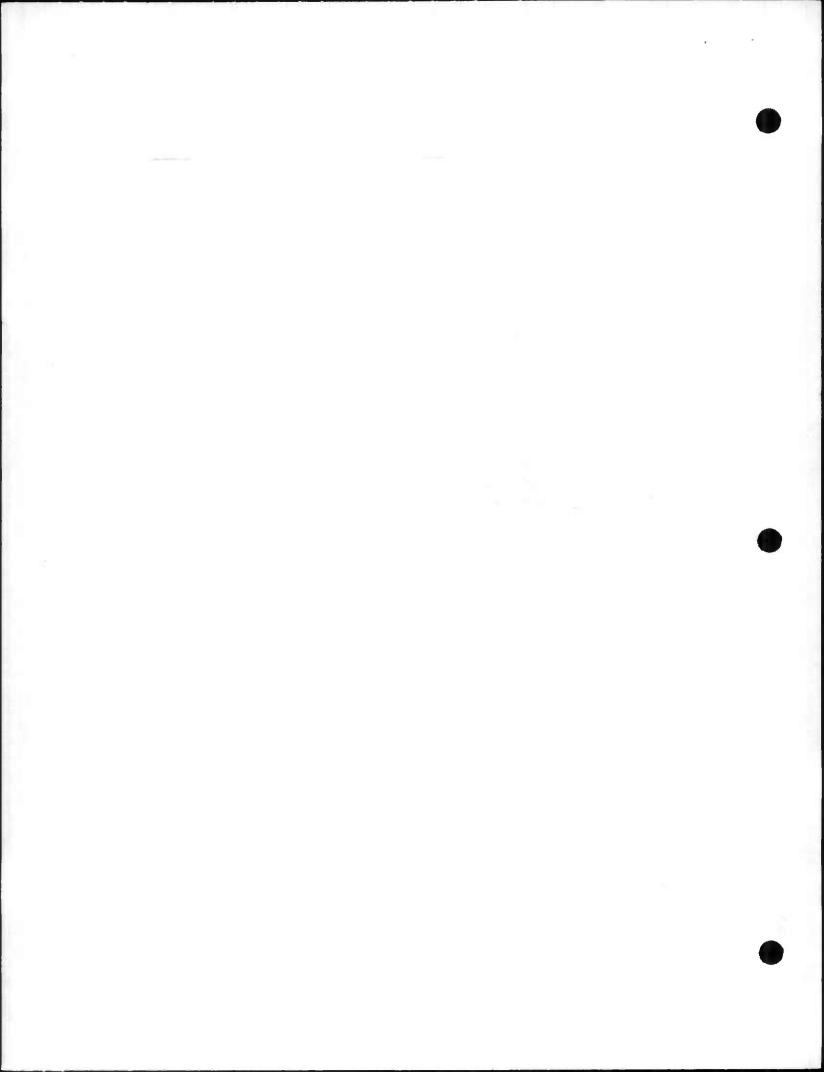
32. REGISTRAR'S SIGNATURE

MC

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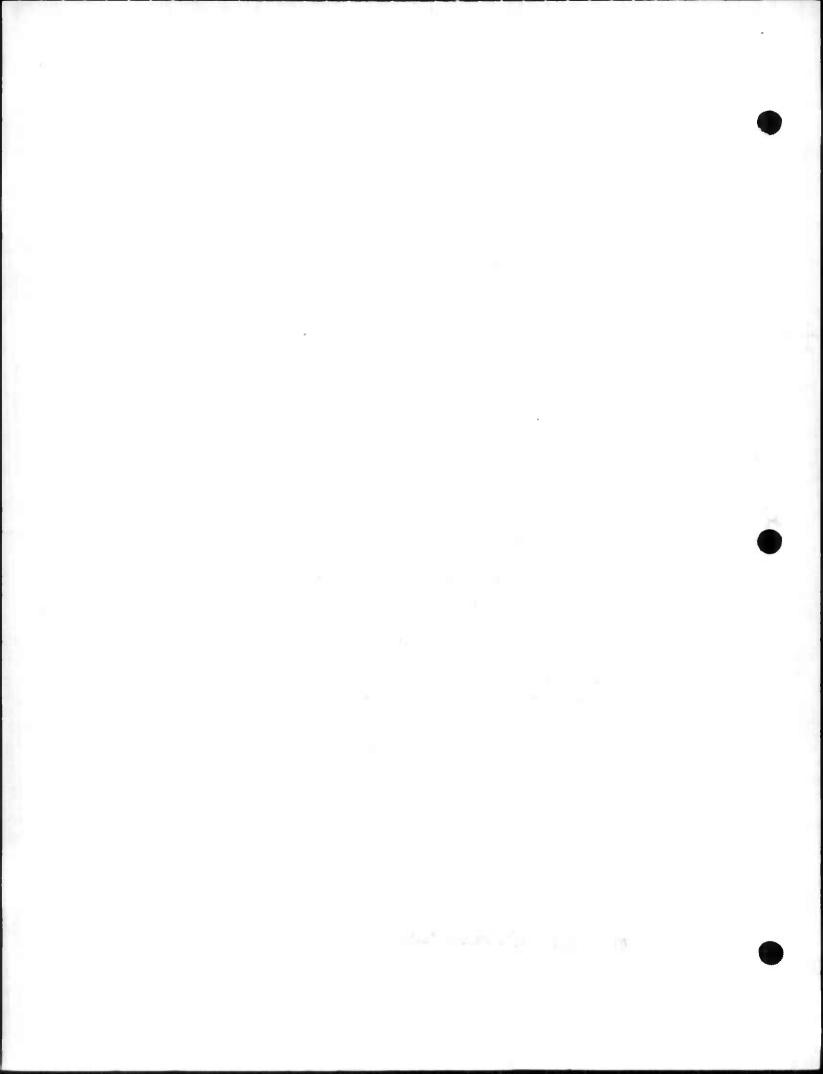
20331-6600

Andrews AFB



1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH DAY YEAR MONTH DAY YEAR										
		Lola B.	Wils	on			April 2					
		4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS,	7. DATE OF BIRTH	8. 80	IRTHPLACE (State or Foreign			
무	1	7.6 17-00 1277	□ M 2 □ M 88	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	07/	MALYLAND			
3 should	E E	99. FACILITY NAME (If not institution, give street Wicomico Nursii			96. CITY, TOWN OR LOCATION OF DEATH Salisbury			9c. COUNTY C	COMÍ CO			
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT	ing frome					NTCOMITCO				
Pages	I BE	10a, STATE 10b, COUNTY	omico		TY, TOWN OR LOCATION 10d. INSIDE C LIMITS? 1 Des 2							
emit.		10e. STREET AND NUMBER		2		H. ZV COOE		10g. CITIZEN (1 NO PES 2 NO			
burial-transit permit.	FUNERAL	703 EAST	Rd			1 2180	5/	u	54			
urial-tr		11. MARITAL STATUS 12 1 Never Married 2 Merried	2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2		13. WAS DE If yes, s	CENDENT OF HISPAN pecify Cuben, Menica	HC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No- 14. F	RACE — American Indian, Black, White, atc.			
as the b	ВУ	3 Divorced	IF YES, GIVE WAR OR DATES		1 🗆 YE	S 2 Specify	f:	s	Black.			
for use a	TED	15. DECEDENT'S EDUCAT (Specify only highest grade con	npleted) (G	CEDENT'S I ive kind of w Do NOT use	ork done during m	ION ost of working	16b. KIND OF BUS	INESS/INDUSTR	ry .			
	COMPLET	Elementary/Secondary ((-12))	College (1-4 or 5 +)	~	mostic	ن	Pril	to -	famile.			
detach once,	SON	17. FATHER'S NAME (First, Middle, Last)	14./			16. MOTHER'S NA	ME (First, Middle, Melden	Surname)	1 1			
od bluc	BE	GEORGE WICSON CASSIE ESTRICA DUTTO STATE 190. IMPORTMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street end Number of Rural Route Number, City or Town, State, Zip Code)										
filled in by the funeral director, page 5 should be detached on, or removal. he medical examiner must be notified at once.	임	XOU DAVIS	190	735	ADDRESS (Street	A BST OV	SL CIR	1 -	, 0<.			
ector, page must be		20s. METHOD OF DISPOSITION 1 Description Date										
d direct		21. BIGHATURE OF PRINCIPLE LICENSEE										
d in by the funeral dir or removal. medical examiner		V Justle -	Ph		- 5A	Shue	MI	1534 D	2K			
n by the removal		23. PART L Enter the diseases, or com	pilcetions that caused the de	ath. Do n	of enter the m	oda of dying,/suci	h as cardiac or reaple	ratory arreal,	Approximata			
y filled in trion, or a		ahock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) If the the the the the the the the the the										
completely ial, crematic c event, th		disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
nd completely fille burial, cremation, atic event, the	z		Cere bir			Lenie	osdou	1 -	Mehr			
ian and or to bur	CATION	Sequentially list conditions, if any, leeding to immediate	DUE TO APR AS A CONSEC	UENCE OF):				49			
inding physician and c Hygiene prior to buria or other traumatic		cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
	ERTIFI	resulting in death) LAST										
문 물 글	O	PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS										
	DICAL	Decubite	- 111				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	ME I	Jenn	& Pmar	2-6	-			^	1 TES 2 NO			
Dept.	AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL			S NO C		1 🗆					
certificate has been the State Dept. of it or item 23 she	SICIAN	EXAMINER?	OSPITAL: inputient 2 ER/Outputient 3		QTHER:	ne 5 🗆 Residence	6 C Other (Specify)					
with the	PHY	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. IN	JURY AT	28d. DESCRIBE HOW IN	JURY OCCURED)			
After this leath with marked	ВУ	1 Netural 5 Pending 2 Accident Investigation	28e. PLACE OF INJURY At ho			YES 2 NO	10 12 12 12 12 12 12 12 12 12 12 12 12 12					
DIRECTOR: After this of hours after death with item 28 is marked,	TED	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Specify)	me, rerm, a	reet, tactory, one	·a	28f, LOCATION (Street e City or Town, Stete)	nd Number or Ru	rel Route Number,			
hours item	MPLET	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my knowledge, de	eth occurre	d at the time, date	end place, end due	to the cause(a) and men	ner as stated.				
TO THE FUNERAL be filed within 72 h IMPORTANT: If I	COM		On the basis of examination and/or i						se(s) end menner es atated,			
Filed w	BE (29b. SIGNATURE AND TITLE OF CERTIFIER	72			29c. LICENSE NUM	IBER	29d. DATE SIGN	NEO (Month, Day, Year)			
E 8 E	6	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF BEATH (ITES	27) (Since	Print)	D02026		Spa	12891			
		F.G. Arthes, M.D.	. 1622 A Ocear	Pine		lin, Md.	21811	·				
_, [31, DATE FILED (Month, Day, Year)	32. AEGISTRAR'S SIGNATURE	1.11								
H		MAY 01 1995	Java arabata	NAME OF THE PERSON OF THE PERS								



HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT H law 28 is marked as item 23 shaws and internal separation and the marked and an addition as a separation of the separation of th
TO THE	TO THE be filed	MPOR

	ITEMS: 10c,10e,10f,1	5,19a,19b,2	29a, PER F.	.H. F	ILM G-723	5/8/9	5 t.t			9	5	156	12
7.	1 - STATE REGISTRAR	STATE OF I	MARYLAND /		RTMENT OF			MENTAL	HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY MEAN											. TIME OF DEA	TH
	William DeRyee Westervelt 4 25 25 25 25 25 25 25 25 25 25 25 25 25										5 ^R	2:15	P .M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR		R 24 HRS.	7. DATE (OF BIRTH Day, Year)	8.	BIRTHPL Country)	ACE (State or F	oreign
	017-01-8988	1 M 2 F	85	YRS.	MONTHS DAYS	HOURE	MIN.	4/2	6/09	Sp		gfield,	, MA
_	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOW	OR LOCAT	ION OF D	EATH		9c. COUNTY	OF DEA	DEATH	
1 2	Pickersgill, In	С.			Towson					Balt	imon	ce	
DIRECTOR	10a. STATE 10b. COUNT	TY		10c. CIT	Y, TOWN OR LOC	ATION					L	Od, INSIDE CIT	
1 8	MD Balt	imore			Chestn			RVILLE	m MT	21204		LIMITS?	
	10e. STREET AND NUMBER			013	- V	IOI. ZIP COL		TOWSE	11 y 1'46			AT COUNTRY?	NO
FUNERAL	615 Chestnut Av	REENRIDGE C	OURT DD 2	1204	_	-21	204	21093		USA			
3	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. WAS D	ECENDENT	OF HISPA	NIC ORIGIN	? (Specify Ye		RACE -	- American Ind	ien.
8Y F	1 Never Married 2 Married 3 Widowed 4 Divorced		YES 2 TN	10		specify Cub S 2 😿 NO		en, Puarto R	ican, atc.)			White	
	4	<u> </u>				- A					.,,.	WILLE	
I	15. DECEDENT'S EDU (Specify only highest grad		16a. DE(CEDENT'S	USUAL OCCUPAT work done during i se retired.)	TION nost of work	ing	16b.	KIND OF BU	SINESS/INDUS	TRY		
1 2	Elementary/Secondary (0-12) Yes	College (1-4 or 5	*)										
COMPLETED		100	Inat	istr.	ial Eng	7				neerin	g		
		17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)											
BE	William DeRyee Westervelt Emma Margaret Gannon 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number of Biral Boulin Number City of Favor Street Fire Street Control												
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zip Code) 101 GREENRIDGE CT., LUTHERVILLE TO B. 615 Chestnut Ave., Towson, MD 21204 21093												
120	20a. METHOD OF DISPOSITION 1XXX Murial 2 ☐ Cremation 3 ☐ Ran	noval from State	cemetery, cres	metory or a	OF DISPOSITION (472	/ 20c. LC	CATION - City	or Town	, Stata	,
E	4 Donation 5 Other (Specify)		Ches	tnut	Grove	e Pre	sby,	1 95	Jac	ksonvi	lle	Md.	
	21. SERVICE L	CENSEE H			22. NAME	AND ADDRE	SS OF FA	J.	J.Ha	rtenst	ein	Mortua	ary,
	Mary 19	Mergah								tstown		. 1736	3
	23. PART i. Entar the diseases, or ahock, or heert fallure.	Complication the	caused the decise on each line.	ath. Do i	not anter the m	ode of dy	ing, suc	h aa cardi	ac or reap	iretory arrest	,	Approxim	
2	IMMEDIATE CAUSE (Final												
£	disease or condition resulting in death)	· Cer	e 500	VA	scolv	~	HC	Crd	enl			3	lays
	disease or condition resulting in death) a. Cevebro VASLUM Accident 3 Rays Due to (OR AS A CONSEQUENCE OF):												
ERTIFICATION	Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):												
Y AT	if any, leading to immediate cause. Enter UNDERLYING	cause. Enter UNDERLYING											
	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):							1	
F	reaulting in death) LAST	d.											
5 O													
MEDICAL	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE												
Ď	DEDIEZZI	· ·						- 1	1 TYES 2	2 HO		OMPLETION OF DEATH?	CAUSE
Σ	DID TODA COO HAS CONT										- 1	YES 2	NO
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA					ERTAII	NA			<u></u>		
PHYSICIAN:	EXAMINER?	HOSPITAL:		1	OTHER:	9)							
₹ ×	1 YES 2 MO	1 Inpatient 2	ER/Outpatient 3	DOA 28b, TIM	4 Nursing Ho		esidence						
	1 Netural 5 Pending	(Month, D			URY W	JURY AT ORK? YES 2	- NO	28d. DE\$0	PRIBE HOW I	NJURY OCCUR	ED		
В	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE O	F INJURY — At hon	ne, farm, i			_ 140	28/ LOCA	TION (Street	and Number or i	Drumal Florid	h Alumbar	
COMPLETED	4 Homicide 6 Could not be determined	building,	etc. (Specify)						Town, State)		NOVER FIGUR	e Namou,	
1	29a. CERTIFIER (Check only 1) CERTIFYING PHYS												
ŏ	one) 2 MEDICAL EXAMINI	ER: On the beels of a	xamination and/or in	nveatigatio	n, in my opinion,	death occu	red at the	time, data a	nd place, an	d due to the c	evee(a) ar	nd manner as a	itated.
BE	296. SIGNATURE AND TITLE OF CENTIFIE	1					ENSE NUI		_	29d. DATE SI	GNED (M	onth, Day, Year)	
10	4/1/	My	~	~			62			141	25	195	
-	Dr. Anthony Riley	, Greate	r Baltimo Baltimo	ore	Medical	Cent	er,	6701	N. Ch	narles	St.		
	31. DATE FILED (Month, Day, 1995	BE REDISTRA	PS SIGNATURE	re,	riu. ZIZ	U 1				<u>-</u>		1 (1	
10	יייייייייייייייייייייייייייייייייייייי	1	market and	-									

THE SEASON

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O.

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ISION OF VITAL RECORDS, P.O. BOX 88/80	The law requires that the death certificate be executed within 24 hours after
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5	TENDING PHYSICIAN: TH
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been stoned by the attending physician and completely filled in by the funeral director came 5 should be described for use as the hurst-praced named by the attending physician.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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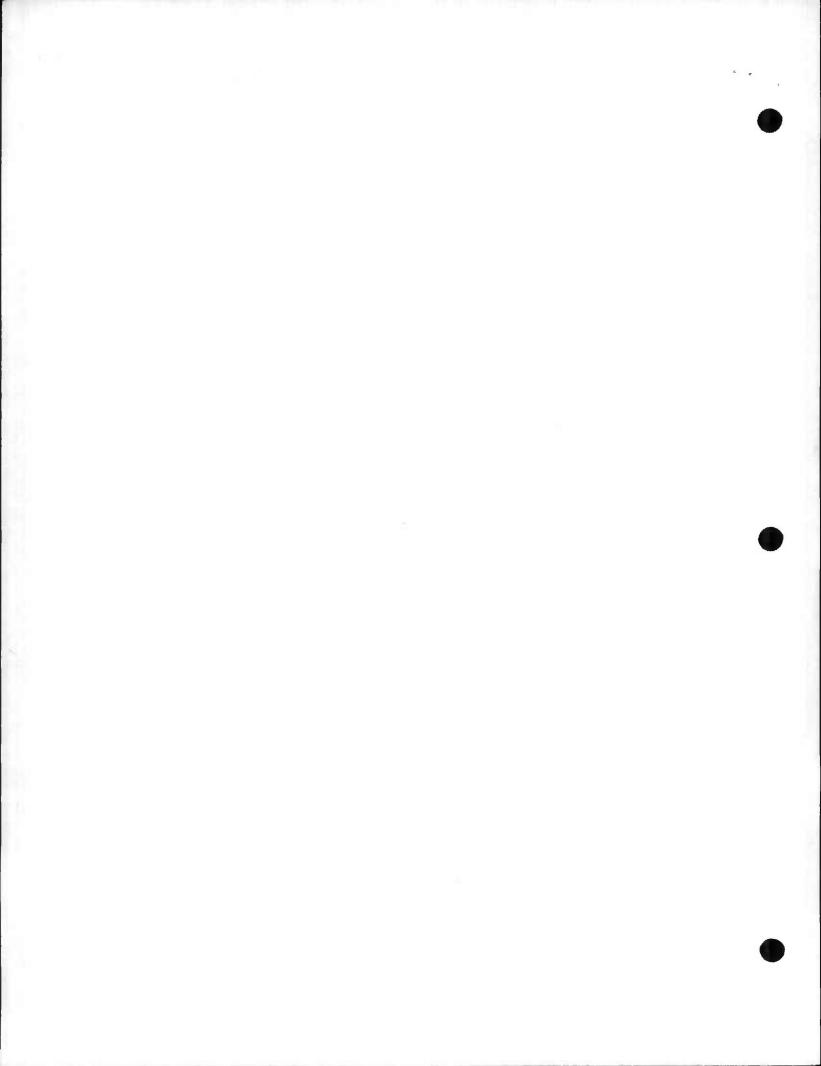
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last) VIVIAN D	• YOUNG				2. DATE OF DEATH WONTH - 28-	95	YEAR	TIME OF DEATH	
	579-54-3741	□ M 2 🖔 F 5	yrs. lest birthday) IF 4 YRS. MON	Country)	HRTHPLACE (State or Foreign country) ash. D.C.					
TOR	96. FACILITY NAME (If not institution, give street end number) 2704 Colebrook Drive 96. CITY, TOWN OR LOCATION OF DEATH Prince Ge									
DIRECTOR	100. STATE 10b. COUNTY Maryland Prince								I. INSIDE CITY LIMITS? YES 2 NO	
	100. STREET AND NUMBER 2704 Colebrook D	101. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U	S_ARMED	13. WAS DECI	20748 ENDENT OF HISPAN	VIC ORIGIN? (Specify Y		United States		
BY	3 🛛 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DATE	ES	1 🖺 YES	2 X NO Specify			Amer	frican- ican	
COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) Co	oleted) bliege (1-4 or 5 +)	6a. DECEDENT'S USU (Give kind of work in the Do NOT use retained to the Cope Pa	done during mos ired.)	t of working	16b. KIND OF B				
▼	17. FATHER'S NAME (First, Middle, Last)		cope ra	IN DAC		ME (First, Middle, Maide	rnmen	τ		
BE	Adolphus 190. INFORMANT'S NAME (Typo/Print)	Henry				ice Moss				
2	Wanda D. Young		2436 E.	ROSE	croft	Route Number, City or To Village	wn, State, Zip C Cir.	ode) Oxon	Hill, Md	
	20a. METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE DISPOSITION (Name of Specify) Park Ceme 5/2/95 Landover, Md.								100	
	21. BIOMATURE OF FONEIRAL SETTINGS LICENSES		TIL	22. NAME AN STEW	ADDRESS OF FA	NERAL HO	ME	E., Wash. D.C.		
N	Approximate interval Between Onset and Death List price (Constitution) But TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death List price (Constitution) But TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury that initiated events resulting in deeth) LAST	CAUSE (Disease Dr injury that initiated events CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF):								
HYSICIAN: MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2							AMA COI OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH?	
AN	DID TOBACCO USE CONTRIBU	26.	PLACE OF DEATH (C		UNCERTAIN	1 🗆				
YSIC	1 YES 2 NO 1	OSPITAL: Inputient 2 - ER/Outputle	ent 3 DOA 4	HER: Nursing Home	5 Residence	8 Other (Specify)				
BY PH	27. MANNER OF DEATH 1 Statural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 Y	RY AT RK? ES 2 NO	28d. DESCRIBE HOW	INJURY OCCUI	RED		
ED	2 Accident Investigation 3 Suicide 8 Could not be determined City or Town, Stele) 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, Stele)							Number,		
COMPLET	29e. CERTIFIER (Check only one) 1 SERTIFYING PHYSICIAN: On MEDICAL EXAMINER: On								menner en stated	
H H	296. SIGNASHINE AND TITLE OF CERTIFIES	6			29c. LICENSE NUN	IBER	29d. DATE-S		oth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CON	v 6850	& Wood	Yard		Clivren,	20			
	31. DATE FILED (Month, Day, Year) MAY U4 1995	32. REGISTRAR'S GIGNATU	IRE L							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. OECEDENT'S NAME (First, Middle, Last) DAVID JOS	EPH YI	N 6 4	LING		- -		2. DATE OF DEA	DAY	YEAR 1995	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. las	t birthday)	F UNDER 1 YEA		24 HRS.	7. DATE OF BIRT (Month, Day, Y	N bar)	, ,	PLACE (State or Foreign
pino		220-32-3382 9e. FACILITY NAME (If not institution, give street	1 XM 2 F	83	YRS.				10/3/			yland
3 should	CTOR	96. FACILITY NAME (If not institution, give street end number) 96. Carroll County General Hospital Westminster 96. County of Death Carroll										
55	<u>E</u>	PRESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d INSIDE CITY										
r. Page	DIREC	Maryland Carr	011			tmin						10d. INSIDE CITY LIMITS? 1 YES 2 NO
permit	ERAL	10e. STREET AND NUMBER				10f, ZIP COD	E		10g. CI1	ITIZEN OF WHAT COUNTRY?		
an. transit	NER	2300 Hughes Sho					2115				ited	States
ling physician. the burial-transit permit. Pages 1, 2,	BY FUN	1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 🔼 N	MED O	If yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, W						- American Indian, White, atc. White
attend ise as	ED	15. OECEDENT'S EDUCA' (Specify only highest grade co	TION empleted)	16e. DE	CEDENT'S US	UAL OCCUP	ATION most of working	00	16b. KIND (F BUSINESS/IN	,	
oltal or atte	LET		College (1-4 or 5+)	Me.	Do NOT use n	etired.)			200	. au 1 + u	120	
detache once.	COMPLI	17. FATHER'S NAME (First, Middle, Last)		Idi	ner		vesto		agi.	icultu	ire	
should be detached strong at once.	BE C	Tobias	Yingling				100000	th		usbaum	1	
5 should notified	5	190. INFORMANT'S NAME (Type/Print) Barbara Jean Jo	bson						ve, Te			21204
f, page		Barbara Jean Jobson 1000 Kenilworth Drive, Towson, MD 2 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE of DISPOSITION (Name of 100) 20c. LOCATION - City or Town, Stetle cometery, cremetery or other place)										
age 6 may director, p		4 Donation 5 Other (Specify)	ey Ce	mete	ry T	Vestmi	nste	r, MD				
death. Pag tuneral dir I. examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE			Pr		Fune	eral Ho			
the for the formal.		23. PART I. Enter the diseases, or cor	itto - Surit	ir		41	2 Was	hing	ton Re	d., We	stmi	nster, MD
executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran to burial, cremation, or removal. matic event, the medical examiner must be notified at once.		IMMEDIATE CAUSE (Final	A CUTE SU DUE TO (OR AS A	B D U	KAL				as carolec or	reappratory as	1001,	Approximate Interval Batween Onset and Death Hours
th certificate be ending physician I Hygiene prior i or other trau	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infiliated evants resulting in death) LAST	DUE TO (OR AS A		,							
s that the dear ned by the att aith and Menta any Injury,	EDICAL C	STROKE PERFOI								AS AN AUTOPSY ERFORMED? ES 2 PRO	D? AVAILABLE PRIOR TO	
requires been sign of Heal	Σ	ATRIAL FIREUL ATION									1 TYES 2 NO	
has be Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			E OF DEATH			ERTAIN				
PHYSICIAN: The law requiths certificate has been with the State Dept. of irked, or litem 23 sho	YSIC	1 TES 2 TVNO 1	IOSPITAL: ☑Inpatient 2 ☐ ER/Outp		_ 0	THER:		sidence 8	☐ Other (Specifi	1)		
NG PHYSIC fler this ce eath with the	РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)		28b. TIME O	1	INJURY AT WORK?		28d. DEŞCRIBE I	IOW INJURY OC	CURED	
NOING I H. After r death	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At hor	ne, farm, stree		YES 2		28t. LOCATION (S	treet end Numbe	r or Rumil Ro	ute Number
ECTOR: S after	ETEC	4 Homicide determined	building, atc. (Spec	fy)					28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
HOSPITAL OR ATTENDING FUNERAL DIRECTOR: After within 72 hours after death ITANT: If Item 28 Is mai	COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIA 2 MEDICAL EXAMINER:										end menner ee stated.
TO THE FUNERA TO THE FUNERA De filed within 7 IMPORTANT:	i w l	296. SIGNATURE AND TITLE OF CERTIFIER					-	NSE NUME				Month, Day, Yeer)
5 5 8 8 5 5 5 8	TO B	M WIN M WY 30. NAME AND ADDRESS OF PERSON WHO					DIS	540)	► M	ay 7,	1795
		MARTIN MAGRAM					0 40 (1	1186	E WEST		•	21157
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	TURE			-116 9	11.50	- 00001		-1"	((1))
		11111 1000	1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1	1								



[6] in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should or removal. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, frours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely. While by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	TIZGIGITITITI				OAIL				n	EG. 140.			
	1. DECEDENT'S NAME (First, Middle, Last)	Irene '	YEAGER						2. DATE OF D	PLAT	Y 100	YEAR	3. TIME OF DEATH
	Daisy						May	4,	DAY 1995 YEAR 10:45 PM M				
	4. SOCIAL SECURITY NUMBER 217-54-9374	5. SEX 1 M 2 KF	6. AGE (In yrs. Ia	st birthday) YRS.	MONTHS	DAYS	HOURS	MIN.	May 18, 1908		8. BIRTH Countr Ma:	8. BIRTHPLACE (State or Foreign Country) Maryland	
	9a. FACILITY NAME (If not institution, give st	and the second second			9b. CITY			ON OF DE			9c. COU	NTY OF D	
0 E	Meridian Nursing			Fre	deri	ck			F	rede:	rick		
E	10a. STATE 10b. COUNTY			10c, CIT	Y. TOWN C	OR LOCAT	ION						10d, INSIDE CITY
FUNERAL DIRECTOR	Maryland Fred								LIMITS? YES 2 NO				
RAL	100. STREET AND NUMBER 21 East South S			10	zip cod 21	701				S.A.	VNAT COUNTRY?		
NS I	11. MARITAL STATUS	12. WAS DECEDER	NT EVER IN U.S. A				ENDENT (OF HISPAN	IIC ORIGIN? (Sp			14. RACE	E — American Indian,
B	1 Never Married 2 Married 3 X Wildowed 4 Divorced	FORCES?	MAR OR DATES	МО			ecify Cubi 2XXNO		n, Puerto Ricen	i, atc.)			White, etc. White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working lifts. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY													
COMPLETED	Elementary/Secondery (0-12)		se retired.) nemal					Own I	Home				
ON	17. FATHER'S NAME (First, Middle, Last)						16. MOT	HER'S NAI	ME (First, Middle	e, Malden	Surname)		
BE C	Charles		Elli					Anna				Hapt	
10	19e. INFORMANT'S NAME (Type/Print) William H. Yeager, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. 433 South Market St., Frederick, M.												and 21701
	20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	of dispos Olivet	Ceme	etery	metery, crei Mary	natory or 7 8, 1	B, 1995 Frederick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0255 MO0255 MO0255 MO0256 MO0256 MO0257 MO0													
	23. PART I. Enter the diseases, or of shock, or heart failure.	complications the	et daused the d	eeth. Do r									Approximate
	IMMEDIATE CAUSE (Fine)	Liet only one ce	use on eech lin	e. •									Onset and Death
	disease or condition e. PYLUMMIA. DUE TO (OR AS A CONSEQUENCE OF):										5 WK		
2													
CERTIFICATION	Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING	OUE TO	OUE TO (OR AS A CONSEQUENCE OF):										
FIC	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSE	OUENCE O	F):								
ERT	resulting in death) LAST	d											
	PART II. Other eignificant condition	e contributing to	deeth but not	reculting	in the U	nderlyln	g ceuse	given in	Part I. 24s	. WAS AN		246	. WERE AUTOPSY FINDINGS
S	emantire h	eat for	iTure	Ur	ina.	4	baci	(se	11×1 11	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL						, ,		,	$\equiv 1^{\circ}$,		OF DEATH? 1 YES 2 NO
ä													
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	☐ ER/Outpatient		OTHE	R:			eck only one)				
H	27. MANNER OF DEATH	200. DATE O		28b. TIM	-	_	JURY AT	asidence	8 Other (Sp 28d. DESCRII		NJURY O	CCUREO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month,	Day, Year)	IN.	JURY M		YES 2 [□ №					
COMPLETED E	3 Suicide 8 Could not be 4 Homicide determined	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At hom building, stc. (Specify)					en .		281. LOCATIO City or To	N (Street a wn, State)		er or Rural	Route Number,
PE	29e. CERTIFIER (Check only	CIAN: To the best o	f my knowledge, d	eath occurr	ed at the	time, date	and place	, and dua	to the cause(a) and mar	ner aa st	ited.	
One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause									the cause(a) and manner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIES	/1 1						ENSE NUM					(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL	JSE OF OEATH (IT	EM 27) (Type	, Print)		Ъ.	31058)		M	ay 5	, 1995
	Dr. Gene F. Ashe	MD Wo	odsboro	Medi	ica1	Cen	ter,	Wood	lsboro	, Mai	ryla	nd 2.	L798
	31. DATE FILED (Month, Day, Year) MAY 08 199	32. REGISTA	AR'S SIGNATURE	Rarball									



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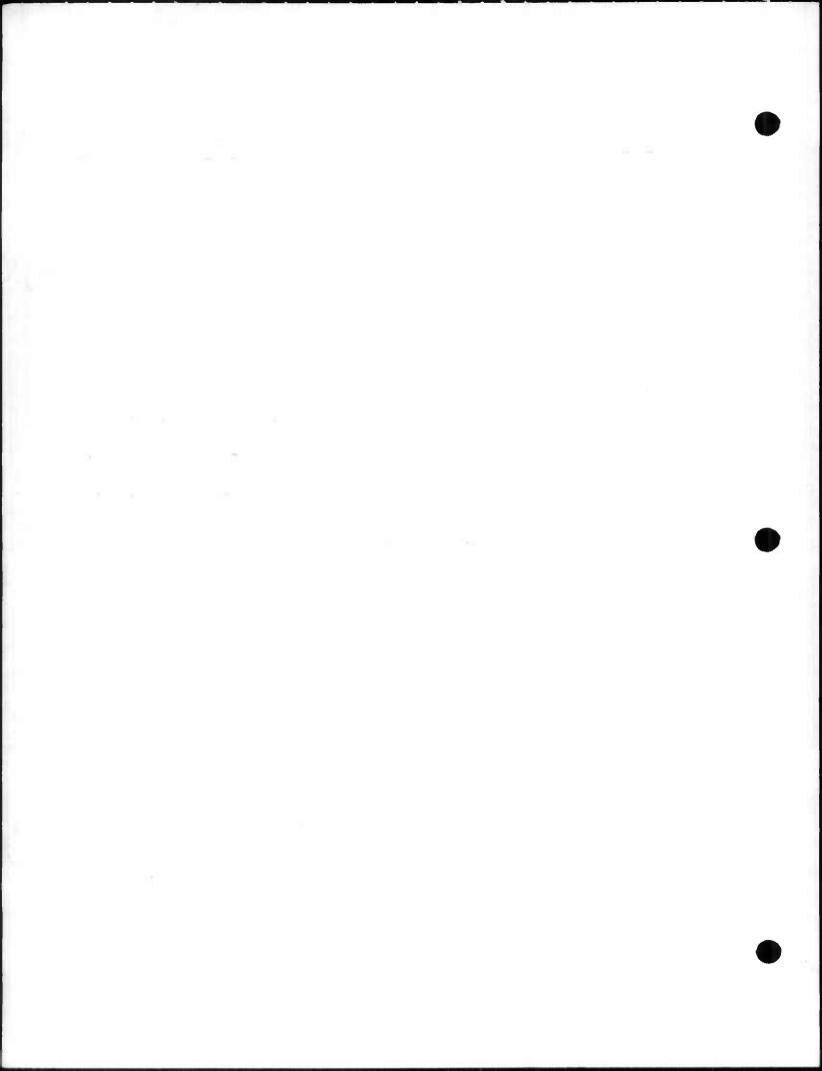
BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the constitution of the most of the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 2, 3 should	Le filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
1)	•		١

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTI	FICALE	OF DEA	TH	RE	G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF O	EATH DAY	YEAR	3. TIME OF DEATH	
	EMMANOUIL MICHAE	L ALEXIS					MAY				
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthde	y) IF UNDER 1 Y	EAR IF UNDE	R 24 HRS.	7. DATE OF BI	RTH	8. BIRT	HPLACE (State or Foreign	
	217-92-3728	51 YRS	THE YES. MONTHS DAYS HOURS N			2-20-	Vejar)	Coun	reece		
	9e. FACILITY NAME (If not institution, give s	treet end number)		9b. CITY. TO	WN OR LOCAT	ION OF DE			c. COUNTY OF		
œ	Stella Maris Hos	nice		Tows					Baltim		
DIRECTOR	RESIDENCE OF DECEDENT			TOMB	011				Daltim	ore	
Ä	10e. STATE 10b. COUNT	Y	10c. (CITY, TOWN OR	OCATION					10d. INSIDE CITY	
5	Maryland Ba	altimore	E	Baltimo	re					LIMITS?	
7	10e. STREET AND NUMBER	-			10f, ZIP COD	Œ		1 10	a. CITIZEN OF	WHAT COUNTRY?	
FUNERAL	19 Glade Avenue				2123	36			Gree		
3	4 MADITAL STATUS										
							n, Puerto Rican,	stc.)	Blac	CE — American Indian, ck, White, stc.	
a 3 AWidowed 4 Divorced								White			
	15. DECEDENT'S EDU	CATION	16a. DECEDENT	'S USUAL OCCI	PATION		16b. KIND	OF BUSINE	SS/INOUSTRY		
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use refired.)											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 17. FATHER'S NAME (First, Middle, Last) Mig. Cho Of J. Frampo 2010 A 2 or inc. 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working like. Do NOT use retired.) Restaurateur 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY 16b. KIND OF BUSINESS/INOUSTRY											
0	17. FATHER'S NAME (First, Middle, Last)				16. MOT	HER'S NAM	ME (First, Middle,	Maiden Sun	name)		
	Michael Emmanuel	Alexis					Fragak				
8	19a. INFORMANT'S NAME (Type/Print)	-	19b, MAILI	NG ADDRESS (S					teta Zin Codal		
2	Jeannette Nimon			Allspi						21117	
1	20a. METHOO OF DISPOSITION	1,	0b. PLACEAND OAT			,			ION — City or T		
	20a. METHOO OF DISPOSITION 1- Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	emetery crematory of	r other place!	•		1				
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Oak Lawn	Lemet	E AND ADDRE	DO OF EAC	15-201	Balt	imore.	Md.	
		matikes	,	Ma	thews	Fune	ral Ho	ne			
	Unn S.	, , , , , , , , , , , , , , , , , , , ,		302	21 East	ern .	Ave., I	Balti	more, M	Id. 21224	
	23. PART I. Enter the diseases, or a shock, or heart failure.	complications that caus	ed the deeth. De	not enter th	mode of dy	ing, such	aa cardiac o	r reapirate	ory arrest,	Approximate	
	IMMEDIATE CAUSE (Final									Interval Between Onset and Death	
	disease or condition resulting in death)	LUNG	CANC	ER						MOS.	
Ì			A CONSEQUENCE								
z											
CERTIFICATION	Sequentially flat conditions, If any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OF):							
2	CAUSE (Disease or Injury	c									
E	that initiated events	DUE TO (OR AS	A CONSEQUENCE	OF):							
11	reaulting in death) LAST	d									
	PART II. Other algnificant condition	a contributing to death	hut not conclude	e le the male	dular anna	-1					
EDICAL		e continuently to destin	Dut not reautill	g iii tire unde	lying cause	given in F	Part 1. 24a.	WAS AN AUT		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
ă							1 🗆	YES 2	NO	COMPLETION OF CAUSE OF DEATH?	
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE	OTHER:	one)						
XS.	1 TYES 2 XNO	1 Inpatient 2 ER/Ou	ritpatient 3 🗆 DOA		Home 5 🗆 Re	esidence (M Other (Spec	elfy) Ho	spice		
표	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)		IME OF 28 NJURY	WORK?		28d. DEŞCRIBE	ULNI WOH	RY OCCURED		
B⊀	2 Accident Investigation				YES 2	□ NO					
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COMPLETED	4 Homicide determined						,	,,			
2 1	290. CERTIFIER Check only	CIAN: To the best of my kno	wledge, desth occu	irred at the time	date end piece	, end due t	to the cause(s)	end menner	es stated.		
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	296. SIGNATURE AND TITLE OF CERTIFIER										
8	Cendago C	Paro 6.	101 111		29c. LICI	ENSE NUMI	BER A D	29	d. DATE SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE CO	SATURTON		19) c	700	73		9/19	/45	
	DR. KENDALL FAU 31. DATE FILED (Morith, Day, Year)	LKNER 2300 32 REGISTRAR'S SIG	DULANEY	VALLEY	RD.	TOWS C	N. MD	2120	4		
H	JI. DATE FILED (MON(N, DBY, Y98/)	1 32 BEGISTRAR'S SIG	MATHER								
	MAY 2 2 1995		Redell								



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TO THE HOSPITAL TO THE FUNERAL DE fled within 72 h IMPORTANT: If i	TO THE MOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation immoral. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the minder examiner must be notified at once.
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FOR STATE REGISTRAR		STATE OF 1	MARYLAND / CE	DEPAR RTIF	ICATE	OF H	DEA	AND	MENTAL HYGII				
Philip	, Middle, Last)	. AL	reas						2. DATE OF DEATH	DAY 20 /	YEAR 995	3. TIME OF	DEATH 5
4. SOCIAL SECURITY NUME 220-20		5. SEX 1 M 2 F	6. AGE (In yrs. last	birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	MIN,	7. DATE OF BIRTH (Month, Day, Year)		Countr	PLACE (State Y) PRYLI	
98. FACILITY NAME (If not in	w ste		c+				HUS	ON OF D		9c. COL	LTI	MOR	e
RESIDENCE OF DEC 10e. STATE	10b. COUNTY		-11	10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDI	E CITY
				RBUTUS							LIMITS 1 YES	67	

4. SOCIAL SECURITY 220-2 9a. FACILITY NAME (# DIRECTOR 1237 BI RESIDENCE OF 10a. STATE MARYLAN 10e, STREET AND NUR FUNERAL 10f. ZIP CODE 1237 BREWSTER STREET 10g. CITIZEN OF WHAT COUNTRY? 21227 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married BY 1 TES 2 NO Specify: 3 Widowed 4 Divorced "White IWWI COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gre Elementary/Secondary (0-12) College (1-4 or 5+) WARCHOUSEMAN Food 12 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname)
KATHERING R. SIN 17th Philip J. AKERS SR. BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KATHERINE E. AKERS 1237 Browster Street BAUTIMORE, MARYLAND 20a METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State MEASON Ridge MemoRIAL 5/23 DORSEY, MARYLAND □ Donation 6 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN 2. NAME AND ADDRESS OF FACILITY AMBROSC FUNCKAL HOME OF LAWS DOWNE 2719 HAMMUNDS FERRY ROAD, BANTO: Md: 7 ART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death Cardiovasallas diseane disease or condition resulting in death) enosc eron DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS Exen word AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: TES 2 NO OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5 Residence 6 ☐ Other (Specify) 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1-Natural 5 Pending BY 1 YES 2 NO Investigation 2 Accident 3 Suicide 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29 g. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) J. Crosson 207632 5-22-9 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print) J. CROSSAN 2112 DUNDALL AVE BITLIO MD 31. DATE FILED (Month, Day, Year) MAY 2 2 1995

21222

		1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	STATE OF I	MARYL	AND / DEPA CERTIF					REG. NO			
		FRANCES		SART			BIN	ICK				YEAR	ME OF DEATH 2:00A M
DALLINOTHE, MARTILAND ZIZIS-UOZO hours after death. Page 6 may be retained by the hospital or attending physician. To remoral. To remoral. The area of the present of th		4. SOCIAL SECURITY NUMBER 217-44-8331	5. SEX 1 - M 2XXF	6. AGE (/	in yrs. lasi birthday) 49 vrs.	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH June 28,	1945	. BIRTHPLACE	(State or Foreign
	CTOR	9a. FACILITY NAME (If not institution, give : 9527 COPPS H		VE				HERS				Y OF DEATH NTGOM	ERY
	DIREC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT				ry, town o							HSIDE CITY
		10e. STREET AND HUMBER						rg . ZIP CODE				H OF WHAT	
	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed A Divorced	12. WAS DECEDENT FORCES?	YES	2XZNO	13. 1	20879 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Ho— 1 yes, specify Suban, Maxican, Puerto Rican, atc.) 1 YES 22 NO Specify: Specify:						nerican Indian, n, atc.
	ED	15. DECEDENT'S EDU (Specify only highest grade			(Give kind of	DECEDENT'S USUAL OCCUPATION DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/IHDUSTRY							
	COMPLET	Elementary/Secondary (0-12) 12 Years								Furn	iture		
	BE CO	narry spiwak											
	101	Ronald Sartoph			19b. MAILIN 1411	O Oxf	ord	Driv	e, L	ute Number City or Tow aurel, Ma	ryland	l 207	07
		20a METHOD OF DISPOSITION A Department of Comments of		20b. ceme MO	PLACE AND DATE etery, cremetory or unt Leb	of DISPOS other place) anon	TIOH (Ne		May	DATE 20c. LO	Adelp		
		21. SIGHATURE OF FUNERAL SERVICE LI	Gloz	Um	nuer	31 23	EIN 2 CA	HEBR ARROL	EW M	EMORIAL F REET, N.W	UNERAI	HOME HINGT	, INC. ON, D.C.
nety fills nation.		23. PART i. Enter the diseases, or shock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. MULTI	PUE	ith lina.	74!				as cardiac or reap			Approximata interval Between Onset and Death
ath certificate be executionally and the hygiene prior to bure, or other traumatie,	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
that bed by	ابا	PART ii. Other algnificant condition	na contributing to	death bu	ut not resulting	in the un	derlying	j cauaa gi	van in P	PERFOI 1 YES 2	RMED?	AVAIL COMP OF DE	
Dept 23	SICIAN: M	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		F DEATH Y			UNCE	RTAIN			'Y	YES 2 NO
PHYSICIAN: The this certificate ha with the State D rked, or Item	IYSIC	EXAMINER? 1 X YES 2 NO 27. MANHER OF DEATH	HOSPITAL:	ER/Outpa	itlent 3 DOA	OTHER 4 Nurs	: ing Home	- 77.		☐ Other (Specify)			
가 등 등 등	ву Рну	1 Netural 5 Pending 2 Accident Investigation	5 13 0	10 POL	MP 020	JURY M	28c. INJU WOI 1 N	ES 2		BUBTECT S	THBE	D &	EATEV
TOR:	ETED	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE C building,	etc. (Speci	At home, farm,		ry, offica		6	City or Town, State)	and Number or S HILL	PURE POURS N	IAMHERSBY
R AC =	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI MEDICAL EXAMINE	CIAN: To the best of	my knowle	edge, death occur and/or investigati	ed at the th	ne, data Inlon, de	and place, a	and dua to	the cause(a) and me	nner se stated	cause(a) and r	nanner se stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	TO BE C	290. SIGNATURE AND TITAE OF CERTIFIE	the	A				29c. LICEH		ER		GIGNED (Month	
10		MARIO FIGUL	O COMPLETED CAN	MM		, Print)	CULD	rirjo.	DAT	TIMODE M	IA DVI AN	JD 212	0.1
		31. DATE FILED (Month, Day, Year) MAY 2. 2.1995	A PEGETA	THE STREET		I IIVIV	DIK	uui 7	DC 11	TIMORE, I		41-4-L	

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TENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 r	OB: After this cartificate has been signed by the attending physician and completely filled in by the funeral director
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle Last. 2. DATE OF OEATH 3. TIME OF DEATH 1995 BAILEY ALBERT JR. MIAY 18 01:45 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR JE UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 239-54-0993 1 1 1 2 | F 60 N.C. July 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF BEATH 9c. COUNTY OF DEATH Pages 1, 2, 3 DIRECTOR MEMORIAL UNION CITY HOSPITA BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4106 COLDORNE KOAD use as the burial-transit 21229 U.S. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 AND IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Mar 14. RACE — American Indian, Black, White, atc. Specify: Black BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY should be detached for College (1-4 or 5+) ORKER LFRED INDUSTRIES 17. FATHER'S NAME (First, Middle Last) B. MOTHER'S NAME Danzie - Johnson BALLEY BERT MOZ NHOL BE notified 19a. INFORMANT'S NAME (Typo/Print). 19b. MAILINO ADDRESS (Street and Number or Rural Routs 5 SHIRL DAILE 4106 COLBORNE DACT 21229 must be 20a METHOD OF DISPOSITION
1 Description
2 Cremation
3 R
4 Donation
8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of connectory) crematory or other place). SATE 23/20 20c. LOCATION ---Burial 2 Cremation 3 Removal from State Clmeter md examiner 21. MIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
MARCH FUNERA 21215 TUNERAL 1) A A A KU ABASH BALT Ave Md medical 23. PART . Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate 6 IMMEDIATE CAUSE (Final **Onset and Death** Health and Mental Hygiene prior to burial, cremation. the disease or condition infarction 40 card eath with the State Dept. of Heath and Mental Hydene prior to burial, crema marked, or Item 23 shows any Injury, or other traumatic event, resulting in death) OVO MANU
DUE TO (OR AS A CONSE CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE YES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO X UNCERTAIN | PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 TES 2 NO rsing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Ybar) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY death 2 📗 Accident TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after deal IMPORTANT: If item 28 is m 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 X CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the besis of ax ition and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 Union

as the Mark Street on

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BOX 6	
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RECORDS,	
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DIVISION	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

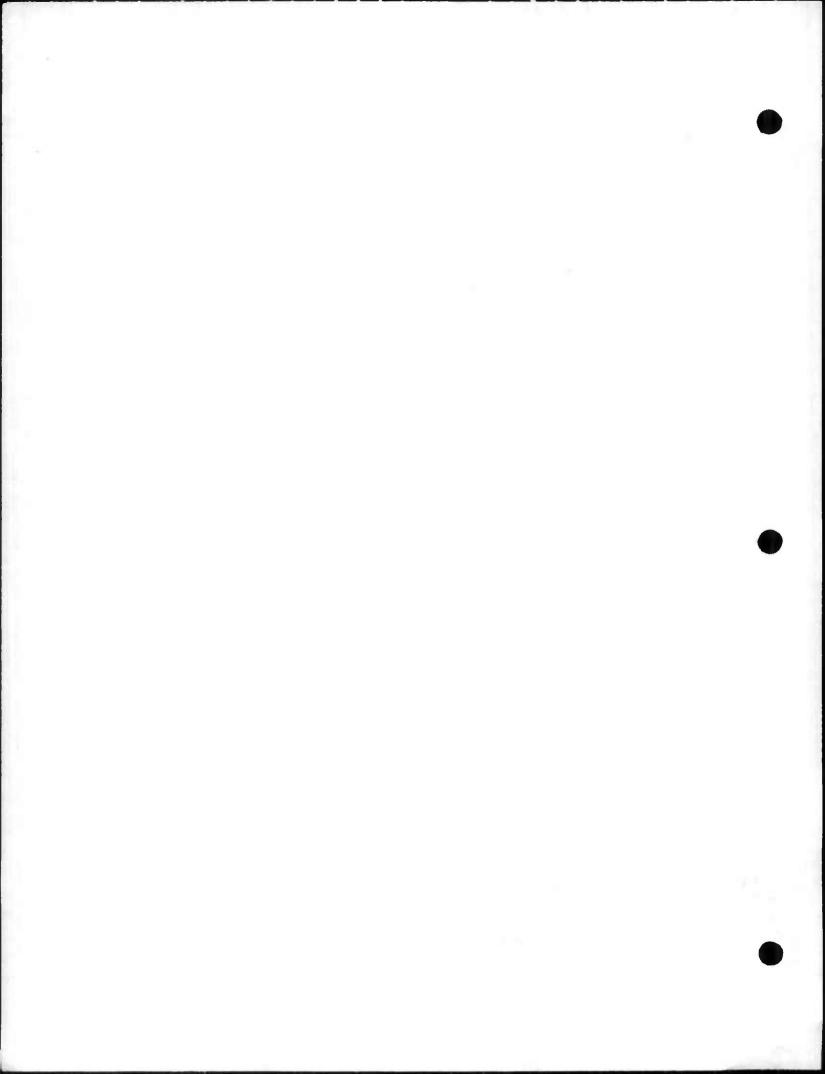
FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
ECEDENTIC MANE (City Military 1 1)		

	REGISTRAR		CERTIFI	CATE C	F DEATH	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATN		3. TIME OF OEATN	
	Charles H. Br:	. Jr.	Jr.			MONTH DAY YEAR		aos	O H	
	4. SOCIAL SECURITY NUMBER 5. SI		rrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF		1995		
- 1				MONTHS DAY		(Month, Da		S. BIHTI	HPLACE (State or Fore try)	lign
	214 30 3470 1	1 34	YRS.			Apr.	14. 19	41 Ma	ryland	
	9e. FACILITY NAME (If not institution, give street at	nd number)			N OR LOCATION OF O		9c.	COUNTY OF	DEATH	
RO	Union Memorial	L Hospital	L	Baltimore City N/A						
5	RESIDENCE OF DECEDENT									
H	10e. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION			1			
ā	MD N/A			BALTIMORE					LIMITS?	ю
7	10e. STREET AND NUMBER				10f. ZIP CODE		10g	. CITIZEN OF	WHAT COUNTRY?	\neg
8	2004 N. Charles Stre		- 1	21218			U.S.A			
FUNERAL DIRECTOR	11. MARITAL STATUS 12. V	MAS DECEDENT EVER IN II	S ARMED	ARMED 13. WAS DECENDENT OF HISPAN			nasity Van as Na	I 44 DAG	E — American Indian	-
	1 To Never Married 2 Married	FORCES? 1 YES	2 NO	NO If yee, specify Cub		n, Puerto Ricar	etc.)	Blac	ck, White, etc.	,
B	3 Widowed 4 Divorced	F YES, GIVE WAR OR OATE	S	1 TES 2 NO Specify			у:		^{c//y:} Black	- 1
	15. DECEDENT'S EQUCATION	y 14	Se. DECEDENT'S	IIOUAL GOOVE	TION				220011	\rightarrow
2	(Specify only highest grade comple		(Give kind of w	ork done during	most of working	16b. KIN	D OF BUSINES	S/INDUSTRY		- 1
ا ت		lege (1-4 or 5+)					0	0 1		1
₹	10th	-	Assembl	y iine	worker		Car	Deale	rship	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTHER'S NA				me)		
BE	Charles H. Brittir	ngham, Sr.			Dorot	hy Sne	ed			
	19e, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rural	Route Number, C	City or Town, Stet	le, Zip Code)		
2	Andre Futrell		1107 i	Elbank	Avenue/Ba	altimor	e, MD :	21239		
	20e. METHOD OF DISPOSITION	20h PI	ACE AND DATEO	E DISPOSITION	(Mamo of	OATE	20c. LOCATIO	M. Chu on T	own State	$\overline{}$
- 1	Buriel 2 Cremetion 3 Removal fr	rom State cemete	ry, crematory or oti	her place)						
- 1		- TOL	shell Me			5/22		imore,	MD	
	22, NAME AND ADDRESS OF FACILITY March Funeral Home East									- 1
	MAIXIX	NAC		110	L E. North	Avenu	e/Balt:	imore,	MD 21202	2
	23. PART I. Enter the diseases, er compl	Cations that caused the	ne death. Do n						Approximat	\rightarrow
	shock, or heart fallure. List o	inly one cause on each	h line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or reappretor	y streat,	Interval Bet	ween
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- 1	disease or condition									
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CERTIFICATION	oue to (or as a consequence of):									
3	cause. Enter UNDERLYING	funt 1	outer	ien l	nelo ca	ndit	9		do	
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E	resulting in death) LAST	MRSA	Sex	2515	> .				da.	.
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DICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PINDINGS									
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MED						' '	123 2 10	´	OF DEATH?	
2	DID TORACCO USE CONTRIBUTE TO CAUCE OF PEATUR MES TO MO TO MASSES TO MO									
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
<u>2</u>	EXAMINER?	SPITAL:	PLACE OF DEAT	OTHER:	ne)					-
YS		Inpatient 2 - ER/Outpatie	ent 3 🗆 DOA		ome 5 - Reeldence	6 Other (Sp	ecify)			- 1
표	N/A	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME		INJURY AT WORK?	26d, OEŞCRII	E NOW INJURY	OCCURED		
ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 1 NO			/		- 1
		28e. PLACE OF INJURY -	At home, ferm, at	treet, tectory, o	ffice	28f. LOCATIO	N (Street end Nu	imber or Rural	Poute Number,	\neg
Ē	3 Suicide 8 Could not be determined City or Town, State) 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, tectory, office City or Town, State)									
9 1	29e. CERTIFIER				VII	L	Te.			\rightarrow
鱼		To the best of my knowledg								
COMPLETED	2 MEDICAL EXAMINER: On	The peels of exemination en	ng/or investigation	s, in my opinio	n, death occured at the	time, date end	place, end due	to the ceuse(e) end manner ee stat	ied.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER	44	29c. LICENSE NUI	MBER	29d.	DATE SIGNED	O (Month/Des: Years/			
									2/17/10	195
유	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF OEATH	I (ITEM 27) (Type,	Print)				f	1/ /	
	mordy Twen	n	4 to	atle	plan	ce c	Min	50 V	nus.	
	MAY 2 2 1905 Jalia	32. REGISTRAR'S SIGNATU	JRE					7		\neg

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	D.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH		
	JOHNNIE		BOYLI			MAY	19. 199			
ERAL DIRECTOR	216 09 53 791	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	7/ 8.	BIRTHPLACE (State or Foreign Country) S		
	9a. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY	OF DEATH		
	THE JOHNS HOPKI	NS HOSPITA	L	BALTI	MORE CITY	7	NI	4		
	10a. STATE 10b. COUNT	N. A		BALTO				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
	14/9 N. CEN	TRAL A	YE	2	01. ZIP CODE			OF WHAT COUNTRY?		
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 20 Widowed 4 Divorced	12. WAS DECEDENT EN FORCES? 14 IF YES, GIVE WAR 11/3/42	YES 2 NO	If yea, a	CENDENT OF HISPA pecify Cuban, Maxic S 2 NO Speci	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	na or No- 14.	RACE — American Indian, Black, White, atc. Specify: Black		
8	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPAT		16b. KIND OF BU	JSINESS/INDUST	RY		
APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT L	work done during in see retired.)	nost of worlding	Be	U. D.	Teel		
E COMP	12 FATHER'S NAME (First, Middle, Last)	las			18. MOTHER'S NA	AME (First, Middle, Maide	n Surname)			
TO BE	19a. INFORMANT'S NAME (Type/Print)	12-1	19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tox	and the second			
	20a. METHOD OF DISPOSITION Pariet 2 Cremetics 1 Page	mai Imm State	20b. PLACE AND DATE		Yeare of	DAJE 20c. L	OCATION CON	1d . 212.13		
	Buriet 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify)) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify)) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify)) DATE 200. PLACE AND DATE OF DISPOSITION (Name of Cemetery, opening of Other (Specify))									
	Oregh b. Lack Dunesal Hony 130471. Central									
	23) PART / Enter the diseases, preshock, or heart failure.	complications that ca List only one cause of	used the deeth. Do on each line.	not enter the m	ode of dying, aud	h as cardiac or reap	piratory arrest,	interval Between		
	immediate cause (Finel disease or condition resulting in death) a. GASTROINTESTINAL BLEEDING							Onset and Death		
	resulting in death)	DUE TO (OR	AS A CONSEQUENCE O	F):	EEDING			Y INIYS		
NOI	Sequentially flet conditions,	b. SEPSI. DUE TO (OR	AS A CONSEQUENCE O	F);				/mo		
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c.									
TIE	thet initiated events DUE TO (OR AS A CONSEQUENCE OF):									
CER	d. CMDIONYOPATHY									
EDICAL	PART II. Other algoriticent condition	s contributing to dea	th but not resulting	in the underlying	ng cause given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE		
MED						1 YES	2 1000	DF DEATH?		
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUS				N 🗆		~		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one OTHER:)					
14S	1 VES 2 NO	1 Nonetlant 2 ER			me 5 🗆 Rasidenca					
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye		JURY W	JURY AT ORK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCURE	D		
8	3 Suicide 8 Could not be determined	28a. PLACE OF IN. building, etc.	street, factory, offica 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLET		CIAN: To the best of my i								
00			nation and/or investigation	on, in my opinion,			nd due to the car	use(a) and manner as stated,		
8	296. SIGNATURE AND TITLE OF CERTIFIER			_	29c. LICENSE NUI	MBER	29d, DATE SIG	INED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	L RESIDENUT	. Print)	404		Fing	7,1755		
	PAUL V. OIDONN	ell, MD	Joins		VS FHUSP	1mL				
	31. DATE FILE (KONT). 27 2 1995	THEGIST ARIS	SIGNATURAL SERVICE SER							



TIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OCCUPATION OF STREET, The Inc. of the state
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 Is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.
--

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD

hould

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH EVELYN MAS 0232 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Yea 6. AGE (In yrs. lest birthday 8. BIRTHPLACE (State or Foreign Country) 218 26 1863 HOURS 1 M 2 X 64 09 14 30 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Deaton Nursing Home Baltimore N/A DIRECTO RESIDENCE OF DECEDENT 10a, STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. N/A Baltimore YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 620 Rappolla Street 21224 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married 2 NO 1 TYES 2 NO Specify ВУ Specify 3 🔀 Widowed 4 🗌 Divorced White 18a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY
Little Tavern (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress 10 Rssteraunt 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Oscar Frederick Henning Margaret Sherman BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Allen Muir 8347 Forest Dr. Pasadena, Md. 21122 20s. METNOD OF DISPOSITION
1 Sturiel 2 Cremation 3 Removal from Stale
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Stata Oak Lawn Cemetery 5-23-95 Eastwood, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. C 6224 Eastern Ave. Balto., Md. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onsat and Death disease or condition RENAL FAILURE ACUTE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY CELEBROVASCULAR YES 2 ANO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) SPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA Nome 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 1 Natural 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED м 1 YES 2 NO Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year,

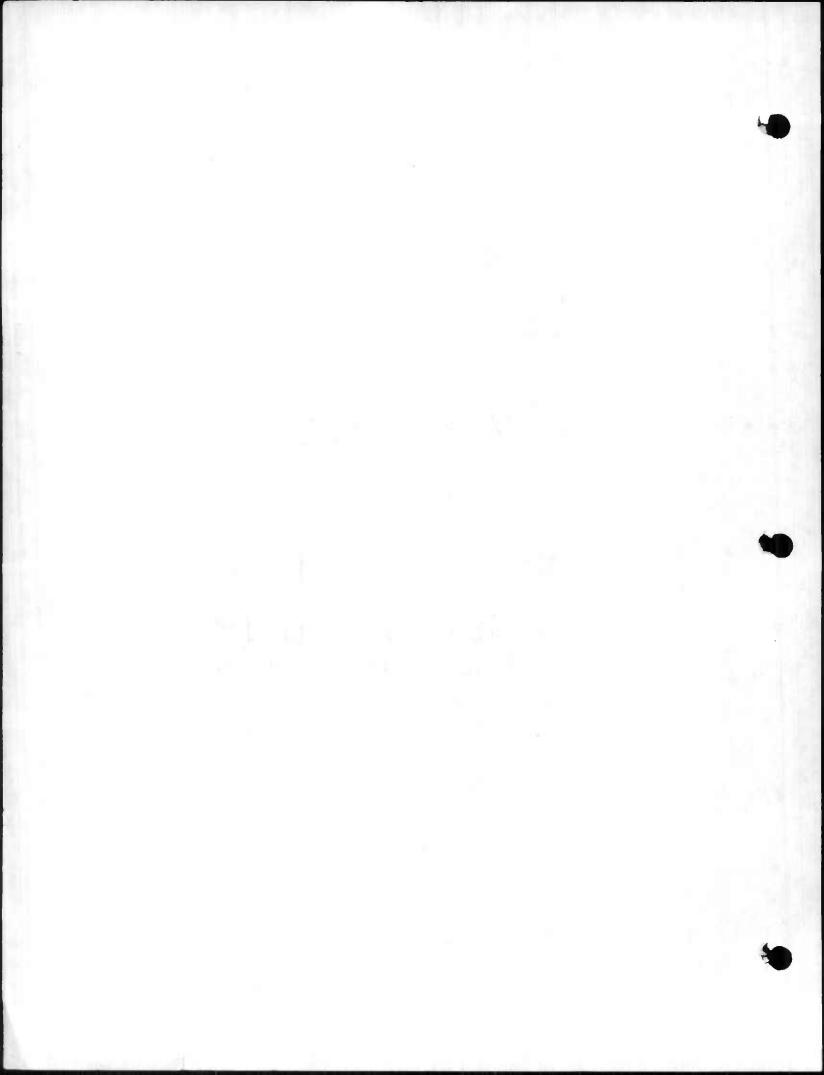
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CERTIFICATE #

95-15623

SEE

CERTIFICATE #

See <u>Eetal</u> Deaths One will be Filed



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physici
_	nours after de
	D
BOX 68760	tificate be executed with
0.	Jeo L
RECORDS, I	YSICIAN: The law requires that the death certificate be executed w
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law
DIVIS	OR ATTEN

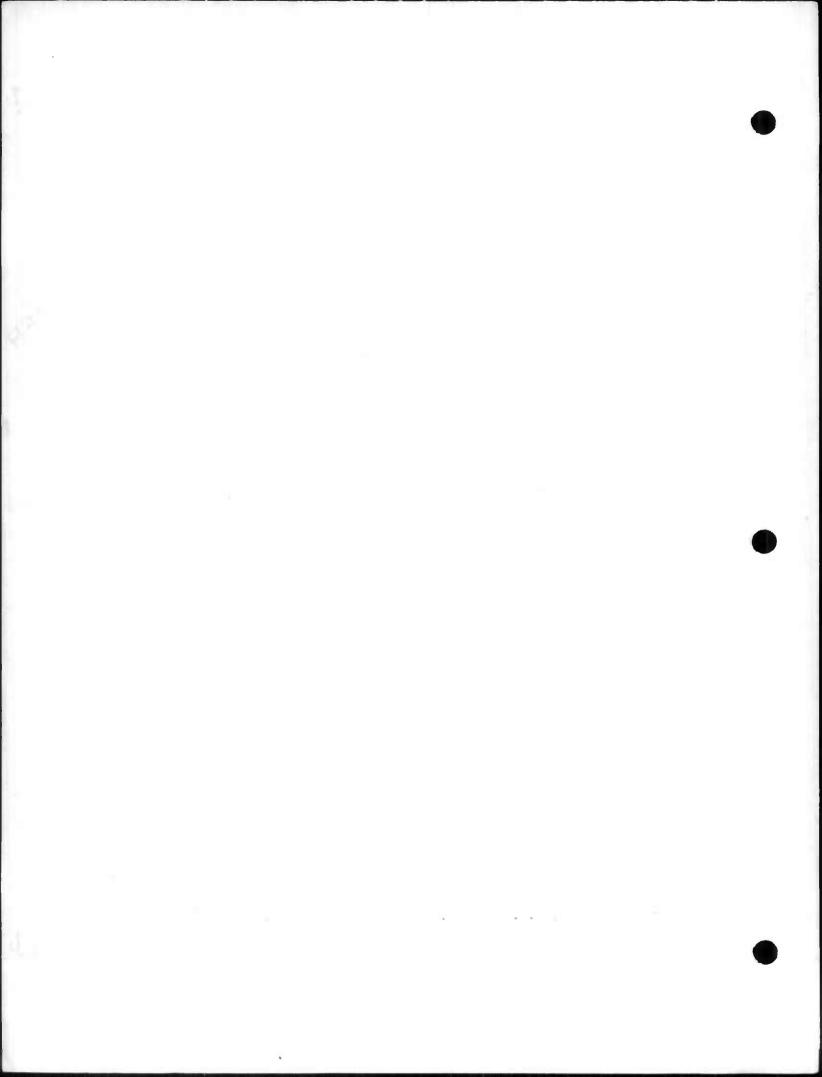
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the indipital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hyglene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

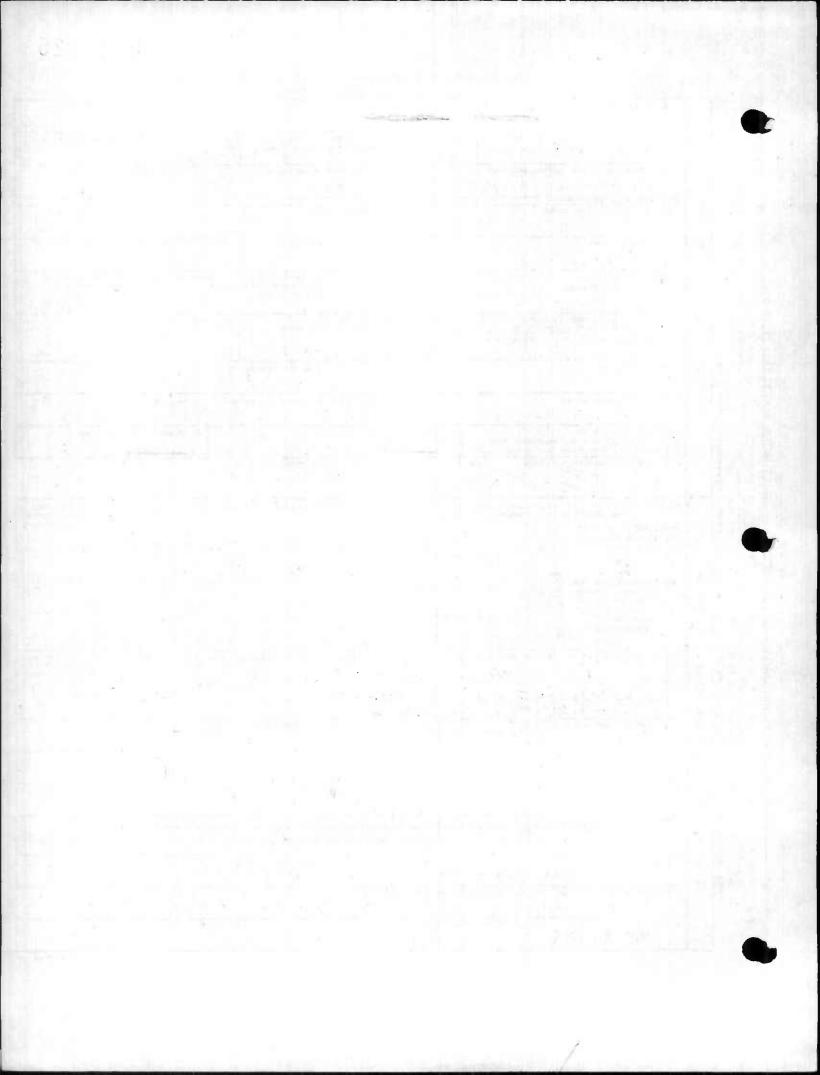
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO).			
i	1. DECEDENT'S NAME (First, Middle, Last) Ànna	E.		BRAG	G	2. DATE OF DEATH MONTH MAY 17	, 1995	3. TIME OF DEATH 10:47 DM		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	IGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		TTHPLACE (State or Foreign		
	216-18-7359	1 M 2 F	80 YRS.	MONTHS DAYS	HOURS MIN.	Oct. 27	Cou	irginia		
	9a. FACILITY NAME (If not institution, give st	- 00	9b. CITY, TOWN OR LOCATION OF D							
DIRECTOR	917 Renfrew St		Ess			Baltimore				
S I	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY									
뜽	Maryland N	/ A	Ba1	timore	imore			LIMITS?		
<u> </u>	10e. STREET AND NUMBER	7.15			of, ZIP CODE		10a, CITIZEN O	F WHAT COUNTRY?		
FUNERAL	1537 Aliceanna				21231	U.S				
ᆵ	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1 1	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	HC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	s or No- 14. R/	ACE — American Indian, ack, White, etc.		
B	3 🔀 Widowed 4 Divorced	IF YES, GIVE WAR			S 2 NO Specify		Specify: White			
15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16s. KIND OF BUSINESS/MDUISTRY										
<u> </u>	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)									
M M	Ó	N/A	Housew	rife		Hous	sewife			
ខ្ល	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maider	Sumama)			
BE	Richard Price				Anna K	inzer				
2	19a. INFORMANT'S NAME (Type/Print) Robert Bragg		19b. MAILING	ADDRESS (Street	and Number or Rural I	Route Number, City or Tox	vn, State, Zip Code)			
-	Robert Bragg		917	Rentre	ew St. E	ssex, MD	21221	21221		
	20a, METNOD OF DISPOSITION t Burial 2 Cremation 3 Remo	oval from State	20b. PLACE AND DATE O cemetery, cremetory or off Oak Lawn	F DISPOSITION (A		1	OCATION — City or			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Oak Lawii		ND ADDRESS OF FA	22/95 Bal	timore,	MD		
	Lilly & Zeiler, Inc. Funeral Homes 1901 Eastern Ave. Balto., MD 21231							ornes		
	23. PART I. Enter the diseases, or c	omplications that car	used the deeth. Do no	ot enter the m	ode of dying, such	h as cardiac or reap	oiratory arrest.	Approximate		
	ahock, or heert failure. I IMMEDIATE CAUSE (Final	List only one cause of	on each line.		,			Interval Between Onset and Death		
	disease or condition	Park to	- bil.							
	resulting in death)	OUE TO (OR	AS A CONSEQUENCE OF): _ 7						
z	Chem Challenter bolowy Space									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF		1					
5	CAUSE (Disease or injury									
	that initieted events resulting in deeth) LAST	DUE TO (OR	AS A CONSEQUENCE OF):						
H I	leading in deetin EAST	í								
	PART II. Other significent condition	a contributing to dee	th but not resulting in	the underlyli	g ceuse given in	Part I. 24a, WAS AF	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS		
DICAL	artonoschouti		mla des-	,		PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
						1 YE\$	ZONO	OF DEATH?		
≥	DID TOBACCO USE	CONTRIBUTE	CAUSE OF	DEATH	YES I NO			1 TYES 2 NO		
₹	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	CAUSE OF		LACE OF DEATH (Ch					
EXAMINER? HOSPITAL: OTHER:										
	27. MANNER OF OEATN	28a. OATE OF INJURY 26b. TIME OF 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCURED								
BY P	1 Natural 5 Pending Investigation	(Month, Day, Year) M 1 VES 2 NO								
	2 Accident Investigation 3 Suicide 8 Could not be	26s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number,								
	4 Nomicide determined	building, atc. (Specify) City or Town, State)								
ן ב	29a. CERTIFIER 1 CERTIFYING PHYSIC	CtAN: To the best of my i	nowledge, death occurred	d at the time, dat	and place, and due	to the cause(s) and ma	nner se eteted			
COMPLET	2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Once we will be the cause(s) and manner as stated. Once we will be the cause(s) and manner as stated.									
_	29b. SIGNATUBE AND TITLE OF CERTIFIER									
8	the Alici 1	29c. LICENSE NUMBER D 18151 29d. DATE SIGNED (Month, Day, Year) > 5/19/95								
일	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE O	F DEATH (ITEM 27) (Time	Print)	0 1013	-	1, 2/13	7 90		
	Chi-Shiang Chen,		N. Broadwa		ltimore,	MD 21231				
	31. DATE FILEO (Month, Day, Year)	32 REGISTRAR'S	SIGNATURE							
	MAY 2 2 1995	Jalia attend	ion Rangell							
		4								



	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Lest)	CLARENCE R	BOWENS	K	2	MONTH D	7 95		
BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 425 -48 - 8998			F UNDER 1 YEAR		DATE OF BIRTH (Month, Day, Year)	8. 6	BRTHPLACE (State or Foreign country) US H	
	80. FACILITY NAME (If not institution, give				OR LOCATION OF DEAT		9c. COUNTY		
	100. STATE 10b. COUNT M. J. N/A	TY .		TOWN OR LOC	ATION			10d, INSIDE CITY LIMITS? 1 YES 2 NO	
	3002 PRESSTULAN			101. ZIP CODE 2/2/6			10g. CITIZEN OF WHAT COUNTRY?		
	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	If yes, s	CENDENT OF HISPANIC pecify Cuben, Mexicen, I S 2 NO Specify:			RACE — American Indian, Black White, etc. Specify: BLACK	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondery (0-12) 7th		16a. DECEDENT'S US (Give kind of wor life. Do NOT use) BAKER/F	rk done during r retired.)	nost of working	UNK	SINESS/INDUST	RY	
MO	17. FATHER'S NAME (First, Middle, Last)		DARBK/1	AT IJK	18. MOTHER'S NAME		Surneme)		
BE C	MONROE BOWENS				OLEVIA				
10	190. INFORMANT'S NAME (Typo/Print) KEVIN C. BOWE	NS			ON AVE.			1216	
	20e. METHOD OF DISPOSITION X Burial 2 Cremetion 3 Ref 4 Donation 5 Other (Specify)	2	Db. PLACE AND DATE OF OTHER PROPERTY OF OTHER PROPERTY.	DISPOSITION (DATE 20c. LC	OCATION — City	or Town, State	
5	DRUID RIDGE CEM. 05-22-95 BALTIMORE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA								
ICIAN: MEDICAL CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	C	A CONSEQUENCE OF):	ntey	t disease atherord	bosic			
	PART II. Other significent condition Page Lyheopa the congultue 25. WAS CASE REFERRED TO MEDICAL	tu mellitu	a Chron	ere de	abetre	PERFO	RMED?	24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 2 YES 2 NO	
SICI	EXAMINER?	HOSPITAL:		OTHER:	PLACE OF DEATH (Check				
BY PHYSICIAN:	27. MANNER OF DEATN 1. Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJUR' (Month, Day, Year	Y 286. TIME	OF 28c, II		8d. DEŞCRIBE HOW	INJURY OCCURE	ED	
ETED B	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State)								
COMPLI	anel .	SICIAN: To the best of my know IER: On the beele of examinat						use(e) end manner ee state	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFI	ER Cam	y		29c. LICENSE NUMBI	40	29d. DATE SIG	SNED (Month/Day, Year)	
Ĕ	30. NAME AND ADDRESS OF PERSON W	Fraus ?	00 U45	trine) Very t	ton Blub	1, 8 alti	, Ma	12/230	
	MAY 2 2 1995	32. REGISTRAR'S SIG	GNATURE						

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH LOWELL BURTON MAY COMER 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign JUNE 11,1920 DAYS 235-28-5838 1 M 2 F 74 VIRGINIA should Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 ST. AGNES HOSPITAL BALTIMORE BALTIMORE CITY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND CARROLL SYKESVILLE permit. 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 338 KINGSTON CIRCLE completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit 21784 U.S.A. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY Specify 3 Wildowed 4 Divorced WW II WHITE 15. DECEDENT'S EDUCATION (Specify only highest grade complete COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 5TH GRADE GRASS CUTTING LANDSCAPING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) RILEY COMER notified at ALABAMA LILLY BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zio Code) 2 JAMES MAKIBBIN 338 KINGSTON CIRCLE - SYKESVILLE, MD 21784 200 205 PLACE AND DATE OF DISPOSITION (Name of 20c LOCATION City or Town, State DATE must PARISBURG CEMETERY 5/24 medical examiner 21. SIGNATURE OF FUND AL SERVICE LICENSEE HUBBARD FUNERAL HOME INC. hours after death. u 4107 WILKENS AVENUE - BALTIMORE, MD 21229 23. PART I. Enter the diseases, or complications that caused the state of the state th. Do not enter the mode of dying, such as cardiac or reapiratory arrest, **Approximate** shock, or haert fellure. List only one cause on east 6 **IMMEDIATE CAUSE (Final Onset and Death** the cremation, disease or condition_ executed within 24 DUE TO IOR AS A CONSEQUENCE OF resulting in death) traumatic event, burial, Pulmine Recurrent Carlingna CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to ALL MANA LA CONSEQUENCE requires that the death certificate be Hygiene prior Wino Portuninector Will. CAUSE (Disease or Injury other DUE TO (OR AS A CON that initiated events resulting in death) LAST 6 any Injury. PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS DIRECTOR: After this certificate has been signed by in hours after death with the State Dept. of Health and AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 1 40 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 Vinpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 27, MANNER OF DEATH 28s. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident Investigation ATTENDING 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 69 6 Could not be COMPLETED 4 Homicide 28 OR O Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) end manner es stated. THE HOSPITAL THE FUNERAL I 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 29b. SIGNATURE AND TITLE OF CENTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3455 WIL AVENUE BAHMAN PARANDI BAL MD mn ORE 0 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 22 1995

Film G, 723, item #9a,5/30/95,cyw, per f.h.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

		ANNA D. DAMESYN MONTH DAY YEAR												TIME OF DEATH	
				E SEV	Leave					May 19, 1995 8:00			8:00 A. M		
		4. SOCIAL SECURITY NUMBER 5. SEX 6. 1 M 2 1 F			8. AGE (In yrs. Is	AE (In yrs. last birthday) AF UNDER 1 YEAR NONTHS DAYS			IF UNDER	24 HRS. MIN.	(Montt	OF BIRTH	B. BIRTHPLACE (State (Country)		
pino		9a. FACILITY NAME (If not in				11100	9b, CITY	TOWN O	OR LOCATIO	ON OF DE		10-14	96 00111	Mary	
2, 3 should	E C	53 Village C	ourt	,				1 A		O. T OF DE			Harf		n
←*	5	RESIDENCE OF DECEDENT													
Page	DIRECTOR	Maryland	N/A	Y					ION						d. INSIDE CITY LIMITS?
регтіі. Pages		10e. STREET AND NUMBER	N/A			Ba.	Ltimo	_	ZIP CODE	-		- 21			YES 2 ND
1Srt pe	8	101.217 0002											U.S.A.		
O sician. al-trar	5	11. MARITAL STATUS	T EVER IN U.S. A		13. W	AS DEC	ENDENT O	F HISPAN	IC ORIGIN	? (Specify Ye		14. RACE -	American Indian,		
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-transit at once.	B⊀	1 Never Married 2 3 Widowed 4 Divo	MAR OR DATES						Black, W Specify:	White					
121 r atter use a	TED	15. DEC (Specify only	EDENT'S EDU highest grade	CATION completed)		Give kind of a	USUAL OC			g	16b.	KIND OF BU	SINESS/IND	USTRY	
O 21	LET	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	We. Do NOT use retired.) Housewife				27 /4					
AND 2 the hospital detached to once.	COMPL	17. FATHER'S NAME (First, M.	iddle, Last)			18. MOTHER'S NAME (F					ME /Eint 1	N/A			
YL/	Ü	Alexander								owska	Sumame)				
MARYLAND retained by the hospit s should be detached notified at once.	TO BI	19e. INFORMANT'S NAME (7)	1	Db. MAILING	ADDRESS	(Street as				er, City or Tow	vn, State, Zip	Code)			
E, M y be ret lage 5 s	ĭ	Mrs. Phyll	is A.	Grupp								Md.			
FORE e 6 may rector, par		20a. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20b. PLACE	ANDDATE	DE DISPOSIT	TION (Na	me of		DATE	200 10	CATION - C	Offy or Town,	Slate
MO direct direct		1. Signature of funeral service licensee Competent of the Competent of												d	
BALTIMORE, er death. Page 6 may by the funeral director, page rai.			P SERVICE LIC	0	,)				WS F			ome			
BALTIMORE, is after death. Page 6 may be n by the funeral director, page removal.		Unn	8.		'eus		302	21 E	aste	rn A	ve.,	Balt:	imore	Md.	21224
3 - 2														Interval Between	
E Eigh		IMMEDIATE CAUSE (Fin disease or condition	in I		OR T	Dul	ma	1/7	28						Onset and Death
760 ed within 24 ompletely fills is, cremation, event, the		resulting in death)			(OR AS A CONSE										SYRS
cxecuted with and complete o burial, crem	Z	Sequentially list conditi		b											
De cian cian for to	CERTIFICATION	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING													
.O. BO certificate be ding physicia lygiene prior other tra	다 인	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEDUENCE OF):													
P.O. th cert ending I Hygie	E	resulting in death) LAST													
* a a a *	- 11	PART II. Other aignifica	nt condition	e contributing to	don'th but not	no culting a	la tha mad	to all lands							
T to A	EDICAL	Tract in Oxfor argunion	The Contraction	e contributing to	deeth but not	reauting	in the und	ieriying	i cense 8	iven in i	Part I.	24a. WAS AN PERFO	RMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE
Sign &		1 TYES 2 1 WO									OF	DEATH?			
E pe es de	2	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	SΠN	ОП	UNC	ERTAIN				10	YES 2 NO
▼ 9 E E	SICIAN	25. WAS CASE REFERRED TO EXAMINER?					H (Check or								
F VITAL SICIAN: The law certificate has the State Dept to or Item 23	YSIC	1 Tes 2 Ne		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:		5 1 80	eldenca (6 🗆 Other	(Specify)			
L. 3 8 8 .	PHY	27. MANNER OF DEATH	Pending	26a. DATE OF (Month, D		26b. TIM INJ	E OF 2	8c. INJL WOI			26d. DE\$	CRIBE HOW	NJURY OCC	URED	
ON ON OING PHYS After this death with	B¥	2 Accident	nvestigation	200 DI ACE D	F M H I I M		М		ES 2 _	-					
ISI TTEN TTEN after	COMPLETED	3 Suicide 8 6	etc. (Specify)	ome, ferm, s	e, farm, straet, factory, office 281. LOCATION (Street and Number or Rurel Rout City or Town, State)				or Rurel Routi	Number,					
DIV TAL OR A TAL DIREC 72 hours If Item	<u></u>			CIAN: To the best of											
HOSPITAL FUNERAL WITHIN 72 TANT: IT	S I	one) 2 MEDI	CAL EXAMINE	R: Dn the beals of a	xamination and/or	Investigatio	n, in my op	lnion, de	eth occun	ed at the t	lime, data	and place, ar	nd due to the	cause(s) an	d manner as stated.
TO THE HOSPIT TO THE FUNER De filed within 7	BE	296, SIGNATURE AND TITLE	OF CENTIFIER	1 m	7				29c. LICE	NSE NUM	UMBER 29d. DATE SIGNED (Month, Day, Year)			onth, Day, Year)	
E 6 9 8	2	30 NAME AND ADDRESS OF	NIV	COMPLETED COM	DE OF OTATION	24.07.5	D35448 11-21-5T								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (17)								6.	mi),	Ko	rnet	if a	1.1/1	my mi
		MAY 2 2	1995	32 REGISTRA	AT'S SIGNATURE	1.11									

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89

BALTIMORE.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO t. DECEDENT'S NAME (First, Middle, Last) Elisabeth 2. DATE OF DEATH 3. TIME OF DEATH 10 P DARAN ELIZABETH 12 C 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH Day, Year) 75 MONTHS DAYS HOURS MIN. Maryland 1 M 2 X F 216-32-1273 YRS. July 1919 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Center Severna Park Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore Maryland Lutherville 1 TYES 2 T NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3 Alston Rd. burial-transit 21093 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 🔀 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Not4. RACE — American Indian, Black, White, atc. MARYLAND 21215-0020 It yes, specify Cuban, Mexican, Puerto Ric 1 YES 2 NO Specify: t Never Merried 2 Married IF YES, GIVE WAR OR DATES Specify BY 3 🔀 Widowed 4 🗌 Olvorced for use as the White 15. DECEDENT'S EOUCATION (Specify only highest grade comple 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INCUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 11 yrs funeral director, page 5 should be detached Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Brunno Weide Alma Stuhn BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Kathleen Spiegel 956 Mt. Holly Dr. Annapolis, Md. 21401 be 20s. METHOO OF DISPOSITION
1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Dulaney Valley 5-22 Timonium, Md. 4 Donation 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. after death. 1050 York Rd. Towson, Md. and completely filled in by the oburial, cremation, or removal. 23. PART i. Enter the diseasea, or complicatione that caused the deeth. Do not enter the mode of dying, auch as cardiec or respiretory arrest, Approximata ahock, or heert feliure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onaet and Death the disease or condition BREAST METASTATIC CARCINONI 6 MM event, resulting in deeth) DIVISION OF VITAL RECORDS, P.O. BOX 68760, The law requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate attending physician cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST the attend PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the Health and PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 TES 2 HO 1 TES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WUNCERTAIN PHYSICIAN: Dept. item 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only ope) State certificate HOSPITAL: OTHED:
4 12 Hursing Home 5 | Rasidenca 6 | Other (Specify) OR ATTENDING PHYSICIAN: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetlant 3 | DOA the or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this co marked, 1 Natural 5 Pending 1 YES 2 NO BY After Investigation 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, tectory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 3 Sulcide 8 Could not be OIRECTOR: / COMPLETED 4 Homicide datarmined Hem 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the ceuse(a) and menner as stated. TO THE HOSPITAL OF TO THE FUNERAL OF THE FUNERAL OF THE MIND 72 hr 2 MEDICAL EXAMINER: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Hend D 9 30. NAME AND ADDRESS OF PERSON WHO'COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7600 CHAIN HWY SURYA MUNDRA #106

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

DHMH-18 Rev 1/89

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BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR		STATE OF I		/ DEPAR					MENT	AL HYGIEN	_		
	1. DECEDENT'S NAME (First,	Middle, Last)									TE OF DEATH			3. TIME OF DEATH
	ROLAND	MAURI	CE DESMAI	RAIS							MAY 9 1		YEAR	12:27 A M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In yrs.	lest birthdey)	IF UNDER 1	YEAR DAYS	IF UNDER	-	7. DAT	TE OF BIRTH		8. BIRTI	HPLACE (State or Foreign
	005-24-2384		1 XM 2 F	64	YRS.	MONTHS	DATS	HOURS	MIN.	Jun	e 18, 19	30	Sant	ord, Maine
9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								DEATH						
NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 100. STATE 101. STATE 102. CITY, TOWN OR LOCATION Virginia Prince William Dale City 102. CITY, TOWN OR LOCATION 103. INSIDE CITY 104. INSIDE CITY 105. CITY, TOWN OR LOCATION 106. CITY, TOWN OR LOCATION 107. INSIDE CITY 1 VIES 2 X								GOMERY						
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								10d. INSIDE CITY						
PE	Virginia	Prince	e William		Dal	e City	7							LIMITS?
AL	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	13870 Langsto	one Dri	ve				2	2193				U.S	S.A.	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S.	ARMED						GIN? (Specify Yes		14. RAC	E American Indian, k. White, etc.
BY F	1 Never Married 2 X 3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DATES				2 NO	Specify		to Rican, etc.)		Spec	
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1	(Specify only	highest grade	completed)		DECEDENT'S (Give kind of Vite. Do NOT u	work done du se retired.)	ring mo	ost of working	ng	1	16b. KIND OF BUS	SINESS/IN	DUSTRY	
PLE	Elementary/Secondary (0-	-12)	College (1-4 or 5	·)	tore S	,					Va. Pow	er		
COMPLETED	17. FATHER'S NAME (First, Mi	iddle, Last)				apor.	1001		HER'S NA	_	t, Middle, Maiden			
BE C	Philias Desma	arais						Lou	ise F	agu	ette			
	19a, INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	(Street a	nd Number	or Rural I	Route Nu	imber, City or Tow	n, State, Zi	p Code)	
٩	Irene Young M			ais	13870	Langs	ton	e Dri	ve, l	Dale	City, V	a. 22	2193	
	20a METHOD OF DISPOSITI	ION on 3 🗆 Reme	oval from State	20b. PLAC	EANDDATE	OF DISPOSIT	ION /Na	me of		P	ATE 20c. LO	CATION -	City or To	
	4 Donation 5 Other	(Specify)		Quan	tico N						-95 Tri	angle	e, Vir	ginia
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEX ///	///		22. N	ame ar OUN	tcast	ss of fa	CILITY	ral Home			
	- Janie	1 1/2	161	//							ale City	-	. 221	93
	23. PART I. Enter the di ehock, or he	iseeses, or c	complications the	caused the	death. Do	not enter t	he mo	de of dy	ing, suc	h as c	erdiac or respi	ratory sr	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Fin		, V											Onset and Death
	disesse or condition resulting in death)	→	sSE	PSIS (OR AS A CONS										
			DUE TO	(OR AS A CONS	SEQUENCE O	F):								
ON	Sequentisily list conditi		b	(OR AS A CONS	EQUENCE O	E)								
FIFICATION	if any, leeding to immed cause. Enter UNDERLY			(61111611161116	LUOLIVOL O	. ,.								
표	CAUSE (Disesse or Injur that initiated events	ry S	DUE TO	(OR AS A CONS	EOUENCE O	F):		-						
CERT	resulting in deeth) LAS		d,											
	PART il. Other significat	nt condition	e contribution to	do oth hut no	non-delan	In the cond		and the second			T		1.	
PHYSICIAN: MEDICAL	An ii. Other aighinoa	in condition	s contributing to	deeth but no	resulting	in the Und	eriyini	g ceuse (given in	Part I.	24a, WAS AN PERFOR		248	AMILABLE PRIOR TO
ED					1						1 TYES 2	NO		OF DEATH?
N.	DID TOPACCO II	SE CONITI	DIDLITE TO CA	LICE OF DE	ATLL		0 F	1 11116	EDTAIN					1 TES 2 NO
AN	DID TOBACCO US		CIBUTE TO CA		ACE OF DEA			JUNC	ERTAI	, 				
Sic	EXAMINER?		HOSPITAL:			OTHER:		6 F D	eldanea		these (Canada)			
Н	1 YES 2 X NO 1 X Inpettant 2 ER/Outpettant 3 QOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY 29. TIME OF 28. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED INJURY OF 28D. TIME OF 28D. TIM													
ВУ Р														
	2 Accident investigation 28e PLACE OF IN HIRTY At home farm street forten editors							Route Number,						
	4 Homicide	datarmined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•					i c	ny or lown, orane)			
PE	29a. CERTIFIER (Check only)	IFYING PHYSI	CIAN: To the best of	my knowledge,	death occurr	ed at the tim	ne, data	and place	, and due	to the o	cause(a) and mar	ner as sta	ited.	
COMPLETED														a) and manner as stated.
	29h. SIGNATURE AND SELLE	OF CENTIFIER						29c. LICI	NSE NUR	MBER		29d. DAT	TE SIGNED	(Mogfft, Day, Year)
O BE	Buch L	Kank	WAS TO					01	01-0	518	13 (VA)	1	5/9	195
2.3			COMPLETED CALL						- C	10	A VA	-	-	/

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

NATIONAL NAVAL MEDICAL

BROOKS D. CASH MC, USN 32. REGISTRAR'S SIGNATURE

BETHESDA MD 20889-5600

31. DATE FILED (Month, Day, Year)
MAY 2 2 1995

Address of the contract of . .

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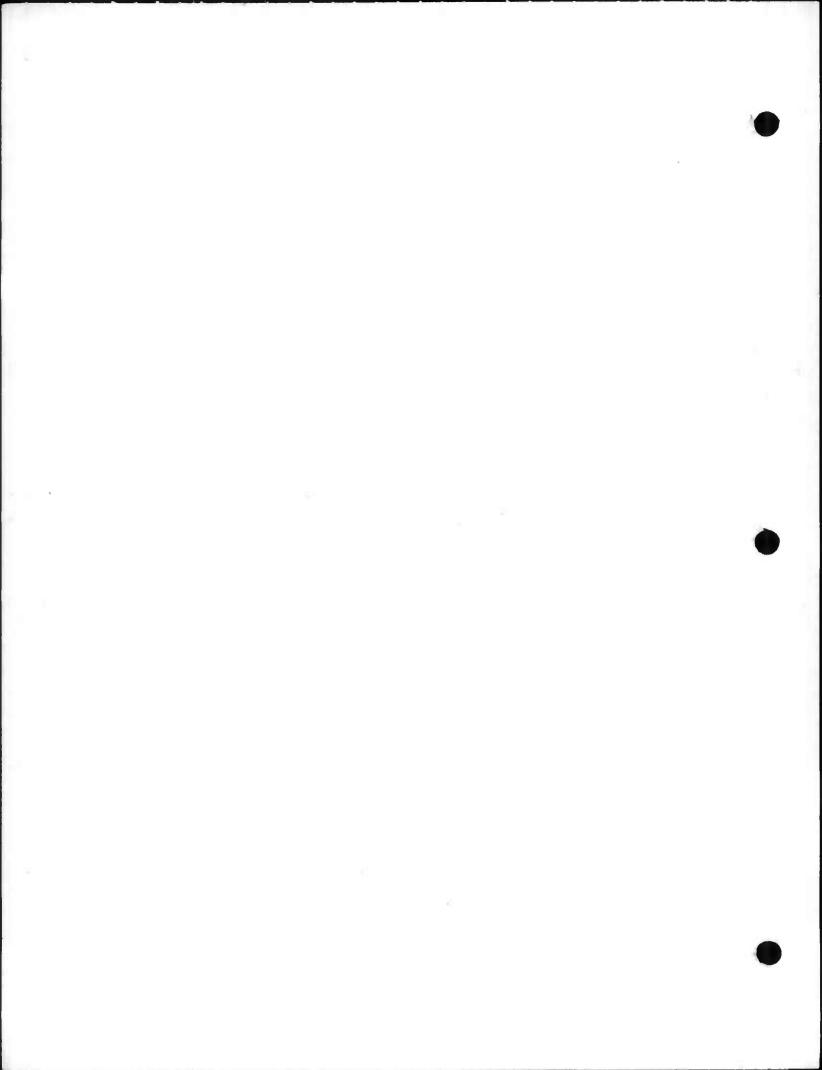
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		1 - STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTMENT CERTIFICATE		MENTAL HYGIEN							
		1. DECEDENT'S NAME (First, Middle, Last) JOHN W	EADDY			2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH 3 1 40 P M					
		4. SOCIAL SECURITY NUMBER 5		s. last birthday) IF UNDER MONTHS MONTHS	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Dev. Year)	8. BIR	THPLACE (State or Foreign intry)					
, 3 should	NC N	Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF D											
s 1, 2,	CT	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		Lan array roum or			14/1						
permit. Pages	- DIRECTOR	Md NA	+	BALT	IMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
sit per	RAI	100. STREET AND NUMBER	2 STREET	-	101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?					
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TLAND ZIZID-UUZU by the hospital or attending physician be detached for use as the burial-trat at once.	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES	□NO If	yes, specify Cuban, Maxic. YES 2 NO Specific	in, Puerto Rican, etc.)	Ble	ack, White, etc.					
use a	Œ	15. OECEDENT'S EOUCAT (Specify only highest grade cor	ION 16a.	OECEDENT'S USUAL OC (Give kind of work done do life. Do NOT use retired.)	CUPATION uring most of working	16b, KIND OF BU	SINESS/INDUSTRY						
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by the hosping of detached at once.	E CON	17. FATHER'S NAME (First, Middle, Last) SOE EAdd	4			ME (First, Middle, Maiden	Sumame)						
A Mained hould hould	00	190-INFORMANT'S NAME (Type/Print)	0 0	19b. MAILING ADDRESS	(Street and Number or Rural	Route Number, City or Tow	n, State, Zip Code)						
may be reto or, page 5 s	5	KEBECCA Ed	lddy	2927 B	AKER ST.	BALTO.	Md.	21216					
9 gg E		20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State carrietery.	CE AND DATE OF DISPOSIT	rmal PK	DATE 20c. LO	Landa	Town, State					
death. Pag tuneral di f. examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN	BEE	22. N	AME AND ADDRESS OF FA	SPAL HOS		EST					
2 2 2 2		1300 Wabash Are Da Ho. Hd. 21215											
filled in by the on, or removal		23. PART . Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or reapiratory arreat, shock, or heart failure. List only one cause on each line. Approximate Interval Batween											
E € 8 €		IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (OR AS A CONSEQUENCE OF): Onset and Death 3 days											
completely nal, cremati, ti		a						3 days					
and and phone	NOI	Sequentially list conditions, Due to (or as a conscouence of): Due to (or as a conscouence of):											
	CATIO	tf any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury											
	RTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
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2 2 2	SA	PART II. Other significant conditions c	ontributing to death but no	ot resulting in the und	eriying ceuse given in	PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
he law requires that has been signed to Dept. of Health am 23 shows any	MEDIC					1 YES 2	XNO	OF DEATH?					
law req as been Dept. of 23 she		DID TOBACCO USE CONTRIB	UTE TO CAUSE OF D	EATH YES N	O UNCERTAI	N I		1 YES 2 NO					
N: The law icate has bo State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	LACE OF DEATH (Check or OTHER:									
SICIAN: Th certificate the State	≟	1 YES 2 NO 1	inpatient 2 ER/Outpatient 28e. DATE OF INJURY		ng Home 5 🗆 Rasidence	8 Other (Specify) 28d. DESCRIBE HOW II	N II IBY OCCUPED						
DING PHYS After this c death with	ву Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	WORK? 1 YES 2 NO		TO THE STATE OF TH						
TTEND! TOR: A after da		3 Suicide B Could not be determined	28e. PLACE OF INJURY — At building, atc. (Specify)	t home, lerm, street, lector	y, office	281. LOCATION (Street a City or Town, State)	and Number or Rura	l Route Number,					
B Pour	PE	29e. CERTIFIER 1 CERTIFYINO PHYSICIAL	N: To the best of my knowledge,	death occurred at the IIn	e, date and place, and due	to the cause(s) and man	nor so stated						
国 政元 =	COMPLET		on the beals of examination and					(a) and manner ea stated.					
TO THE HOSPI TO THE FUNEF De filed within	BEC	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI			D (Month, Day, Year)					
5 5 3 M	2	30. NAME AND ADDRESS OF PERSON WHO C			P07	731	5-1	18-95					

22 S BREENE ST BALTIMORE ST 21201

31 DATE FILED (MODIF) DOWN DEVENE ST 21201

MAY 2 2 1995 July 2 J



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	THE HOSPITAL
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	1 - FOR STATE REGISTRAR	STATE DF MARYL	AND / DEPARTMI	ENT DF HE	ALTH AND				
	1. DECEMENT'S NAME (First, Middle, Last)	FANNI	E NAE	=		2. DATE OF DEATH	DAY	75 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 217-16-3761	1 🗆 M 2 💢 F				7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPL/ Country)	MCE (State or Foreign Hd
10B	Sinai Hosp	1	96.	Bal	LOCATION OF DI	EATH	9c. COUNT	. 1 .	н
111		1	SOC CITY, TON	1.				10	d. INSIDE CITY LIMITS? YES 2 NO
	100. STREET AND NUMBER 4301 Face VI	N		-					
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	It yes, speci	fy Cuban, Maxica	n, Puerto Rican, etc.)			RI-1
8	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of work di	one during most	of working	16b. KIND OF E	USINESS/INDU	STRY	Djack
COMPI	17. FATHER'S NAME (First, Middle.		Durses			ME (First, Middle, Mald		Hol	US
8	JOSEPH E.	Davis	19b. MAILING ADD	RESS (Street and	Glaco Number or Rural	lys Do	own, State, Zip (Code)	
	20a,METHOD OF DISPOSITION			POSITION //Jame	Urers	PATE 200.	LOCATION - CI		21216 State
	4 Donation 5 Other (Specify)	- K	INGS MILIMOR	22 NAME AND	Name .	924/35 Kg	walsto	way N	21215
Ц	23. PART & Enter the cheeses, or	Somplications that caused	The death Do not as	4300	Wash	ach Ace	3	170	Hd
	iMMEDIATE CAUSE (Final	List only one cause on a	ach line,		or dying, suc	n as cardiac or res	piratory arre	61,	Approximata interval Between Onset and Death
-	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):		RUCT	100			12-244
ATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):							
1 55 1	cause (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
A P	PART II. Other significant condition	s contributing to death b	ut not resulting in the	undariying c	ause given in	Part I. 24a. WAS /		AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE
	ARTERY DISE ASI	E, CONGESTIVE HEART FAILURE							
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	MOSPITAL:	26. PLACE OF DEATH (Chi	ock only one)	UNCERTAIN	110			
PHYS	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		Nursing Home 28c, INJUR	Y AT		MNJURY OCCU	RED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, street,		2 🗌 NO	281. LOCATION (Stree City or Town, Stat	t and Number or	Rural Route	Number,
I W I		CIAN: To the best of my knowl	ledge, death occurred at the	ne Ilme, data an	d place, and dua		/	L.	
	2 MEDICAL EXAMINE	R: On the basis of examination		ny opinion, dest	h occured at the	time, data and place,	and due to the	cause(a) and	
	Thomas	Cont			1227	BER	29d. DATE 5	20	195 (Year)
	THOMAS GE	NUIT MI	SINAI	HOSP	ITAL	BALTIM	ORE		
	SWAY 2 1995	John Dewelson R	arlell						DHMM 16 Pau 1/80
	TED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIR	1. DESCRIPT'S NAME (Figs. Middle, Lest) 4. SOCIAL SECURITY NUMBER 21 12 - 3 12 9a. FACILITY NAME (III not institution, give is SIDENCE OF DECEDENT 10a. STATE 10b. COUNT 11. MARITAL STATUS 1	1. DECEDENT'S NAME (First, Micdie, Lest) 1. DECEDENT'S NAME (First, Micdie, Lest) 1. DECEDENT'S NAME (First, Micdie, Lest) 2. SECURITY NUMBER 2. S. SEX 1. DECEDENT'S STATE 3. SEX STAT	THE STATE 1. DECEMBETT'S NAME (FIG. MICKIN, LAST) 1. DECEMBETT'S NAME (FIG. MICKIN, LAST) 4. SOCIAL SECURITY NUMBER 2. THE STATE 4. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 2. SOCIAL SECURITY NUMBER 3. PACILITY NAME (If not inpithidon, give street and number) 10. STATE 10. COUNTY 10. STATE 10. STATE 10. COUNTY 10. STATE 10. Norw Marriad 2 Marriad 3. Windowsd 4 Divorced 11. MARTIAL STATUS 12. MAR SECURITY RAM SECURITY SECURITY 13. DECEMBETT SECURITY 14. MORPHANTS RAME (FIG. MICKIN) 15. DECEMBETT SECURITY 15. DECEMBETT SECURITY 16. DECEMBETT SECURITY 17. FATTHER'S NAME (FIG. MICKIN) 17. FATTHER'S NAME (FIG. MICKIN) 18. MALING ADD 17. FATTHER'S NAME (FIG. MICKIN) 18. MALING ADD 17. FATTHER'S NAME (FIG. MICKIN) 18. MALING ADD 17. FATTHER'S NAME (FIG. MICKIN) 18. MALING ADD 18. DECEMBETT SHAP 19. MALING ADD 19. MALING ADD 19. MALING ADD 19. MALING ADD 19. MALING ADD 19. MALING ADD 19. MALING ADD 19. MALING ADD 20. PLACE AND DATE OF DIS 20. PLACE OF DEATH (COUNTY) 19. MALING ADD 19. MALING ADD 21. SIGNARUNE OF FUNERAL SERVICE UCENSES 22. PLACE (Disease or inclury 19. MARTIN (Other significant conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Please or inclury 19. MARTIN (Other significant conditions contributing to dasth but not resulting in the HILL SECURITY OF	THE DISTARE STATE CERTIFFICATE OF	STATE CREATER CAPT MORE CAPT MORE CAPT CAP	TO STATE OF MAINTAIN AND MENTAL HYBRID POPULATION OF DEATH AND MENTAL	THE DESCRIPT PARTY SAME OF MODE, LETY STATE OF MODE AND STATE AND MENTAL PRISON OF DEATH A. DOCAL SICURITY NAME (IT NO PUBLICATION OF STATE OF AND AND AND AND AND AND AND AND AND AND	STATE OF STATE OF MARKET AND MENTAL HYDRING AND STATE OF

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with chours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Pages 1, 2, 3 should

permit.

Item # 1,10f,19b,22 Film # G 723 5-22-95 N.A. Per Funeral Home 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 199504:10 Kenneth Louis Evans KENNETH EVANS MAY 19 ам 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year, 6. BIRTHPLACE (State or Foreign 213-84-7469 33 DAYS HOURS MARYLAND 1 XM 2 - F VBS 7-14-61 9a. FACILITY HAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE DETENTION CENTER DIRECTOR BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE n/a 1 X YES 2 NO FUNERAL 10e, STREET AHD NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 323 Ε. 21 st STREET 21218 UNITED SA-STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Ho—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 □ YES X ₩ HO Specify 14. RACE — American Indian, Black, White, etc. Never Married 2 Married Specify: BLACK BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIHD OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 ΤĤ JANITOR IAL WORKER CLEANING CO. 17. FATHER'S HAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname JOHN G. **EVANS** MARIE Ε. WHITE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARIE Ε. WHITE 323 Ε. 21 ST STREET, BALTIMORE, MARYLAND # 28 20a, METHOD OF DISPOSITION

A Burlal 2 Cremetion 3 Removal from State 20c. LOCATIOH — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE CEMETERY 4 Donation 5 Other (Specify) 5-24 LANSDOWNE, MARYLAND 21 SIGHATURE OF FUHERAL SERVICE LICENSEE 22. HAME AND ADDRESS OF FACILITY WEM C. MARCH FH.-1101 E. NORTH **AVENUE** Mora Wm. 23. PART I. Enter the diseases, or si cations that caused the deeth. Do not enter the mode of dying, such as cerdlec or respiratory arrest, Approximete shock, or heert fellure. In only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Daeth disease or condition . HIV + ENCEPHALOPATHY VS PML resulting in death) month DUE TO (OR AS A CONSEQUENCE OF END STAGE AIDS
OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, if any, leading to immediate 1 year cause. Enter UNDERLYING WASTING SYNDROME OF SYNDROME OF SYNDROME CAUSE (Disease or injury 1 year thet initiated eventa resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS

24a. WAS AH AUTOPSY PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t TYES 2X HO t TYES 2 NO

25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (Check only one)								
EXAMIHER? 1 VES 2 □ HO	HOSPITAL: 1X Inpatient 2 ER/Outpatient 3	OTHE	R: rsing Home 5 - Realdence	6 □ Other (Specify) I					
27. MANHER OF DEATH 1 X Hatural 5 Pending 2 Accident Investigation	28s. DATE OF IHJURY (Month, Day, Year)	26b. TIN	IE OF JURY M	26c. INJURY AT WORK? 1 YES 2 HO	26d. DEŞCRIBE HOW IHJURY OCCURED				
3 Suicide 8 Could not be	28s. PLACE OF INJURY — At hor building, atc. (Specify)	28s. PLACE OF INJURY — At home, farm, street building, atc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated,

2 MED	ICAL EXAMINER:	On the basis of a	xemination and/or	investigation,	In my opinion,	death occured at	the time, dat	ta and place, and du	a to the cause(a) a	nd manner as stated.

SIGNAL OF CENTIFIER	29c. LICENSE HUMBER	29d. DATE SIGHED (Month, Day, Year)
L'Ilweldo M	D43501	MAY 19,1995
30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		

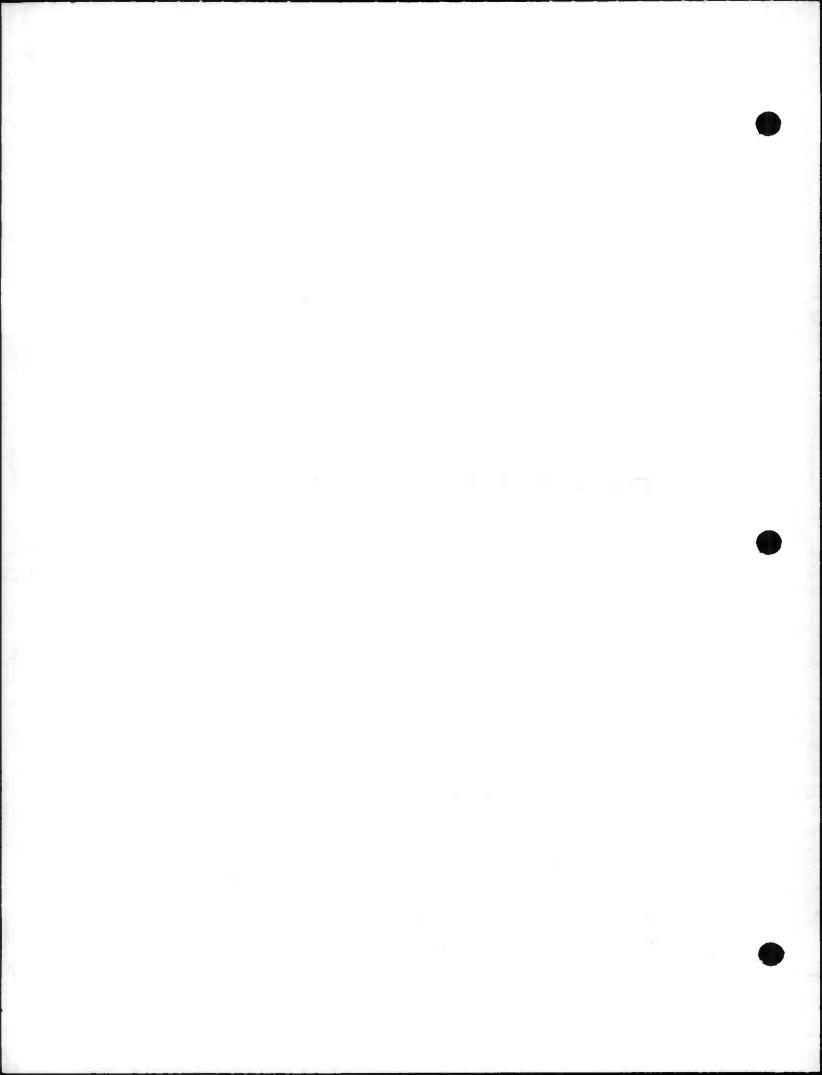
ZERABRUCK TEWELDE 32. REGISTRAR'S SIGHATURE 31. DATE FILED (Month, Day, Year)

1995

determined

BALTIMORE CITY DETENTION CENTER 401 E. EAGER ST. BALT. MD. 2120

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HMS. 7. DATE OF BIRTH 8. BIRTHPLACE (Shallo or Formion	· M
plo		2/3 12 5/15 1 M.M 2 F 70 YRS. MONTHS DAYS HOURS MIN. (Morth, Day, Year) - 25 Country)	
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BALTIMORE, for death. Page 6 may be the funeral director, page val.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE To Go, Locks F. H. 22. NAME AND ADDRESS DE FACILITY 1304 N. CENTRAL AVE 1304 N. CENTRAL AVE	_
BA nours after de of in by the fi or removal.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate	
76C Red within 24 hours after completely filled in by the sul, cremation, or remove event, the medical		shock, or heart fellure. List only one deute on each live. IMMEDIATE CAUSE (Final disease or condition resulting in death)	
6876C ecuted with and complet burial, crer	N	Metastates Carrierana de Suas Years	_
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P.O. B ath certificat tending phy al Hygiene p	ERTIF	that initiated events resulting in death) LAST d.	
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ECOR quires that n signed by I Health an	MEDIC	PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO	
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THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COM	In the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.	
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<u> </u>		MAY 2 2 1995 A DESCRIPTION OF THE PROPERTY OF	
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BALTIMORE, MARYLAND 21215-0020	eath. Page 6 may be retained by the hospital or attending physicia	himaral director same 5 chould be detached for use on the build a
BA	hours after d	filled in hy the f
DIVISION OF VITAL RECORDS, P.O. BOX 68760	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physicia	DIRECTOR: After this certificate has been stoned by the attending physician and completely filled to by the function has a should be determined by the survey of the function

al-transit permit. Pages 1, 2, 3 should an. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the detache TO THE FUNERAL DIRECTOR. After this certificate has been signed by the afterding physician and completely filled in by the funeral director, page 5 should be detached. Be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF		DEPARTMENT				MENTAL	HYGIENE
	CF	DTIELCATE	0	EDEAT	TLI .		000 110

	1 - FOR STATE REGISTRAR	STATE OF MARY		MENT OF HEAL		MENTAL HYGIENI REG. NO.	E		
	1. OECEDENT'S NAME (First, Middle, Las	1)				2. DATE OF DEATH		3. TIME OF DEATH	
	NELSON VAU	JGHN FORD				May 18		11:34 p M	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE		NDER 24 HRS.	7. DATE OF BIRTH	0. BIR	THPLACE (State or Foreign		
	215-16-2172	1 XM 2 - F	74 YRS.	MONTHS DAYS HOU	MIN.	Dec . 31 , 1		Md .	
	9a. FACILITY NAME (If not institution, give			96. CITY, TOWN OR LO	CATION OF DEA		9c. COUNTY OF		
OR	230 Spring Ave.			Luthervil	le		Baltin	ore	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN						Barcin	DIE	
in in			10c. CITY	, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
		altimore		Luthervil				1 TES 2 NO	
FUNERAL	10e. STREET AND NUMBER			101, ZIP (OOE		10g. CITIZEN OF	WHAT COUNTRY?	
NE	230 Spring Ave.				093			S.A.	
E	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS OECEDENT EVER FORCES? 1 XYES	2 NO	13. WAS DECENDED	IT OF HISPANI	C ORIGIN? (Specify Yes, Puerto Rican, etc.)	or No- 14. RA	CE — American Indian, ick, White, atc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 YES 2 🛱				ecity:	
ED	15. DECEDENT'S ED	II-WW-II		JSUAL OCCUPATION		T		White	
	(Specify only highest gra-	de completed)	(Give kind of wi	ork done during most of w	orking	16b, KIND OF BUS	INESS/INDUSTRY		
퓝	Elementary/Secondary (0-12)	College (1-4 or 5+)		,		_ ,			
COMPLET	17. FATHER'S NAME (First, Middle, Last)		меспаптса	1 Inspecto		JONNS HO		niversity	
	Nelson	For	· A			IE (FISI, MIDDIE, MEIDEN S	,		
BE	19e. INFORMANT'S NAME (Type/Print)	101			orgia	oute Number, City or Town		nown	
5	Mr. David Ford								
	20a, METHOD OF DISPOSITION	20		FDISPOSITION (Name of		cville, Md			
	1 Buriel 2 Cremation 3 Re	moval from State Col	metery, crematory or oth	er placel Dankung	d	123 Bal	ATION - City or		
	21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE	ruru Rice	e Cemetery			kesvill	e, Md.	
	200	M				uneral Hom	o Tna		
	TASORE	STO WE		1050 You	ck Rd.	Towson, M	d. 2120	4	
	23. PART I. Enter the diseases, or shock, or heart fallure	Complications that cause	d the death. Do no	ot enter the mode of	dying, such	as cerdiac or respir	atory arrest,	Approximata interval Between	
	IMMEDIATE CAUSE (Final)								
	disease or condition resulting in death)	. 40	ine co	mCl1				150av	
		DUE TO (OR AS	A CONSEQUENCE OF					Je -	
Z	Sequentially list conditions,	b							
Ĕ	If any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF)	:					
CERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or Injury	C							
	that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENCE OF)	:					
H H		d							
AL C	PART II. Other algnificant condition	ons contributing to death !	out not resulting in	the underlying cause	e given in P	Part I. 24s, WAS AN A	WITOPSY 24	Ib. WERE AUTOPSY FINDINGS	
						PERFORI	AED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
						1 YES 2	NO	OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CON	TDIBLITE TO CALISE (OF DEATH YES	WALL III	ICEDTAIN	_		1 YES 2 NO	
NA I	25. WAS CASE REFERRED TO MEDICAL	T T TO CAUSE C	26. PLACE OF DEATH		VCERTAIN				
S	EXAMINER?	HOSPITAL:	750	OTHER:	,	_ 5			
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME			Other (Specify) 28d. DESCRIBE HOW IN	HIPW COCKIDED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU			200. DESCRIBE HOW IN	JOHT OCCURED		
B	2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJURY	/ — At home, term, et			281 LOCATION (Street or	ed Mumbas as Chim	Design March	
	4 Homicide 8 Could not be determined	building, atc. (Spe	cify)	ever, rectory, office		281. LOCATION (Street ar City or Town, State)	id Number of Hura	noute Number,	
COMPLET	29a, CERTIFIER								
d A	(Check only	SICIAN: To the best of my know	rledge, death occurred	at the time, date and pl	ace, and dua to	o the cause(s) and manr	ner ee stated.		
8	The same of the sa	IER: On the basis of examination	m and/or investigation	, in my opinion, death or	cured at the ti	me, date and place, and	due to the cause	(s) and manner se stated.	
BE	296. SIGNATORE AND TITLE OF BERTIFI	ER .			LICENSE NUME		29d. DATE SIGNE	D (Month, Day, Year)	
10	104 Culin	d, NV)			0305	27	· 5/1	9/55	
F	SO. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F	Print)	-				
	Dr. Paul Celan	o 6569 N. Cha	arles St.	Towson, M	d. Sui	te 205			
	31. DATE FILED (Month, Day, Year)	1 32 REGISTRAR'S SIGN	ATURE						
	MAY 22 1995	Jahr Davde	or Narriell						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	law requires that the death certificate be exe
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) THE HOSPITAL OR ATTENDING PHYSICIAN
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	TO

	1. DECEDENT'S NAME (First	t, Middle, Last)		CI	ERTIF	ICATE OF	DEATH	,	REG. NO.			TIME OF SELEC	
1	Edwin		Leroy		יתימת	ΓERMAN		MONT	TH DA		YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUM		-	AGE (In yrs. les		IF UNDER 1 YEAR	IF UNDER 24 HRS.	May	19 OF BIRTH	199		4:15 LACE (State or Fore)	at de
	154-14-8965	5	1 🔀 M 2 🗆 F	73	YRS.	MONTHS DAYS	HOURS MIN.	May	20, 19		Country)	sylvania	-
	9a. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CITY, TOWN	OR LOCATION OF		20, 20	9c, COUNT	_	-	
CTOR	Franklin Square Hospital Center Rossville Baltimor							ore					
W W	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OR LOC	ATION				1	IOd. INSIDE CITY	
□	Maryland		Baltimore			Essex					1	YES 2 N	0
RAL	10a. STREET AND NUMBER					1	Of. ZIP CODE					AT COUNTRY?	
FUNE	1608 French	ns Ave	12. WAS DECEDENT E	VED BUILD AD	450	40 1110 0	21221			US			
BY	1 Never Married 2 3 Divo		FORCES? 1X IF YES, GIVE WAR	YES 2 NO OR DATES	(O	If yes, s	CENDENT OF HISPA pecify Cuban, Mexic S 2 NO Spec	en, Puerto		or No- 14	Black,	- American Indian, White, etc. White	
G	15. DEC	EDENT'S EDU	CATION COMPOSite (1)	18e. DE	CEDENT'S	USUAL OCCUPAT	TON	168	b. KIND OF BUS	INESS/INDUS			
E	Elementary/Secondary (t		College (1-4 or 5+)	Ille.	Do NOT us	e retired.)	iost or working						
COMPL	12 17. FATHER'S NAME (First, M	tide to the		Mac	hinis	st & Ins					nt A	eronauti	ca
	Clair Fett	,					18. MOTHER'S N			Sumeme)			
BE	190. INFORMANT'S NAME (198	. MAILING	ADDRESS (Street	Marce			State Zin Co	orie)		
2	Dagmar Fett	erman					Ave., Ba					3	
	20e. METHOD OF DISPOSIT		oval from State	20b. PLACE	NDDATE	F DISPOSITION (OAT		CATION — CIT		n, State	
	4 Donation 5 Other	(Specify)	STATES AND A	Rosed	ale C	emetery		5/2	2 Ora	ange,	NJ		
	21. SIGNATURE/OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A.												
_	1. De	11/1	titul			6009	Harford	Rd.,	Baltin	more,	MD	21214	
	23. PAST I. Enter the di ahock, or h	eart fallure.	complications that ca List only one cause	on aach lina	ath. Do n	ot enter the m	oda of dying, su	ch aa cen	diac or respir	ratory arrea	it,	Approximata interval Bety	
	IMMEDIATE CAUSE (Fir	nai										Onset and D	
	disease or condition		Caranari	r autar	44								
	disease or condition resulting in death)	→	Coronary		-			_				10 year	rs
z		→	ē	AS A CONSEC	DUENCE OF			-					
TION			DUE TO (OR Aortic s	AS A CONSEC	LS):						10 year	
ICATION	resulting in death) Sequentially list conditi	diete ING	AORTIC S OUE TO (OR	AS A CONSEC	LS DUENCE OF):						10 year	
TIFICATION	Sequentially list condition if any, leading to immecause. Enter UNDERLY!	diete iNG iry	AORTIC S OUE TO (OR	stenos	LS DUENCE OF):						10 year	
CERTIFICATION	Sequentially list condition if any, leading to immecause. Enter UNDERLY CAUSE (Disease or input that Initiated events resulting in death) LAS	diete iNG iry	DUE TO (OR	AS A CONSEC AS A CONSEC AS A CONSEC	DUENCE OF););						10 year	
AL	Sequentially list condition if any, leading to immecause. Enter UNDERLY CAUSE (Disease or injuit that initiated events	diete iNG iry	DUE TO (OR	AS A CONSEC AS A CONSEC AS A CONSEC	DUENCE OF););	ng ceuse given in	Part I.	24a. WAS AN / PERFORI	MED?	A	10 year	rs
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HYSICIAN: MEDICAL	Sequentially list condition if any, leading to immecause. Enter UNDERLY CAUSE (Disease or injust that initieted events resulting in death) LAS PART II. Other significe DID TOBACCO U 25. WAS CASE REFERRED TO	diete ing irry	DUE TO (OR AOTTIC S. OUE TO (OR OUE TO (OR O. OUE TO (OR O. OUE TO (OR O. OUE TO (OR O. OUE TO (OR	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF DUENCE	S NO [H (Check only one OTHER: 4 Nurshing Hot	UNCERTAI DIE S Residence JURY AT	N ⊠	PERFORI	MED?	A C C C C C C C C C C C C C C C C C C C	4 yea: 4 yea: 4 yea: VERE AUTOPSY FINDO MAILABLE PRIOR TO OWNELETION DE CAU F DEATH?	rs
Y PHYSICIAN: MEDICAL	Sequentially list condition if any, leading to immecause. Enter UNDERLY CAUSE (Disease or injust that Initiated events resulting in death) LAS PART ii. Other significe DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 XNO 27. MANNER OF DEATH 1X Natural 5	ont condition. SE CONTRO MEDICAL Pending	DUE TO (OR AOTTIC S OUE TO (OR OR TO (OR OR	AS A CONSECTION OF THE PROPERTY OF THE PROPERT	DUENCE OF DUENCE	S NO L H (Check only one OTHER: 4 \(\text{ \text{ Nonling Hot}} \) H (F) OTHER: 4 \(\text{ Nonling Hot} \) H (F) OTHER: 4 \(\text{ Nonling Hot} \) H (F)	UNCERTAI	N ⊠	PERFORI 1 YES 2 PER (Specify)	MED?	A C C C C C C C C C C C C C C C C C C C	4 yea: 4 yea: 4 yea: VERE AUTOPSY FINDO MAILABLE PRIOR TO OWNELETION DE CAU F DEATH?	rs
ED BY PHYSICIAN: MEDICAL	PART II. Other significe DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 XNO 27. MANNER OF DEATH 1 Netural 5	diete ing iny . T	DUE TO (OR AOTTIC S. OUE TO (OR OUE TO (OR O. OUE TO (OR O. OUE TO (OR O. OUE TO (OR O. OUE TO (OR	AS A CONSECTION OF AS A CONSECTI	DUENCE OF DUENCE OF DUENCE OF DEAT):): n tha underlylr S NO [H (Check only one OTHER: 4 Nursing Hot E OF 28c. IN WY 1	UNCERTAL Description Description Description UNCERTAL Description	8 Other 28d. 053	PERFORI 1 YES 2 PER (Specify)	MED?	A C C O O I	4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 4 yea: 5 eathor	rs
ED BY PHYSICIAN: MEDICAL	PART II. Other significe DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 12 Accident 3 Suicide 4 Homicide PART II. OERT	SE CONTRO MEDICAL Pending investigation Could not be determined	DUE TO (OR AOTTIC S. OUE TO (OR DUE AS A CONSECTION OF AS A CONSECTI	DUENCE OF DUENCE OF DUENCE OF DUENCE OF DEAT DOA 28b. TIME INJ): n tha underlylr h (Check only one OTHER: 4 Nursing Hot C OF 28c. IN W H treet, factory, offil d at the time, dat	UNCERTAI Discontinuo S Residence JURY AT ORK? YES 2 NO	8 Other	PERFORI 1 YES 2 OF (Specify) SCRIBE HOW IN CATION (Street er or Town, State)	MED? [X NO JURY OCCUP Ind Number or	RED Rural Rou	4 yea: 4 yea: 4 yea: WALABLE PRIOR TO OMPLETION DE CAMPLETION DE CAMP	rs MNGS SSE	
D BY PHYSICIAN: MEDICAL	PART II. Other significe DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 12 Accident 3 Suicide 4 Homicide PART II. OERT	SE CONTRO O MEDICAL Pending Investigation Could not be determined TIFYING PHYSIC CAL EXAMINER	DUE TO (OR AOTTIC S OUE TO (OR DUE TO (OR DUE TO (OR A CONTRIBUTE TO CAUS RIBUTE TO CAUS HOSPITAL: 1 M Inpetient 2 = ER 28e. DATE OF INJ (Month, Dey,) 28e. PLACE OF IN building, etc.	AS A CONSECTION OF AS A CONSECTI	DUENCE OF DUENCE OF DUENCE OF DUENCE OF DEAT DOA 28b. TIME INJ): n tha underlylr h (Check only one OTHER: 4 Nursing Hot C OF 28c. IN W H treet, factory, offil d at the time, dat	UNCERTAI Discontinuo S Residence JURY AT ORK? YES 2 NO	8 Other 28d. OES 28t. LOC City to the case of time, dete	PERFORI 1 YES 2 OF (Specify) SCRIBE HOW IN CATION (Street er or Town, State)	MED? [X NO JURY OCCUP and Number or mer ee stated, if due to the c	RED Rural Rou	4 yea: 4 yea: 4 yea: WALABLE PRIOR TO OMPLETION DE CAMPLETION DE CAMP	rs MNGS SSE

and the miles

9c. COUNTY OF CEATN

N/A

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

19

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE - American Indian, Black, White, etc.

WHITE

1 TYES 2 NO

21061

Approximate

Interval Between

Onset and Death

2 months

2 months

2 weeks

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 1 NO

29d. DATE SIGNED (Month, Day, Year)

May 21 1995

8. BIRTHPLACE (State or Foreign

MARYLAND

9,30 A M

REG. NO.

21

2. DATE OF OEATN

7. DATE OF BIRTH

MONTH

5. SEX

1 M 2 X F

R. FRANKLIN

6. AGE (In yrs. last birthday)

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

31. DATE FILEO (Month, Day, Year)

MAY 2 2 1995

FRANCES

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

IF UNDER I YEAR

DAVE

IF UNDER 24 HRS.

BOX 68760

DIVISION OF VITAL RECORDS, P.O.

BALTIMORE, MARYLAND 21215-0020

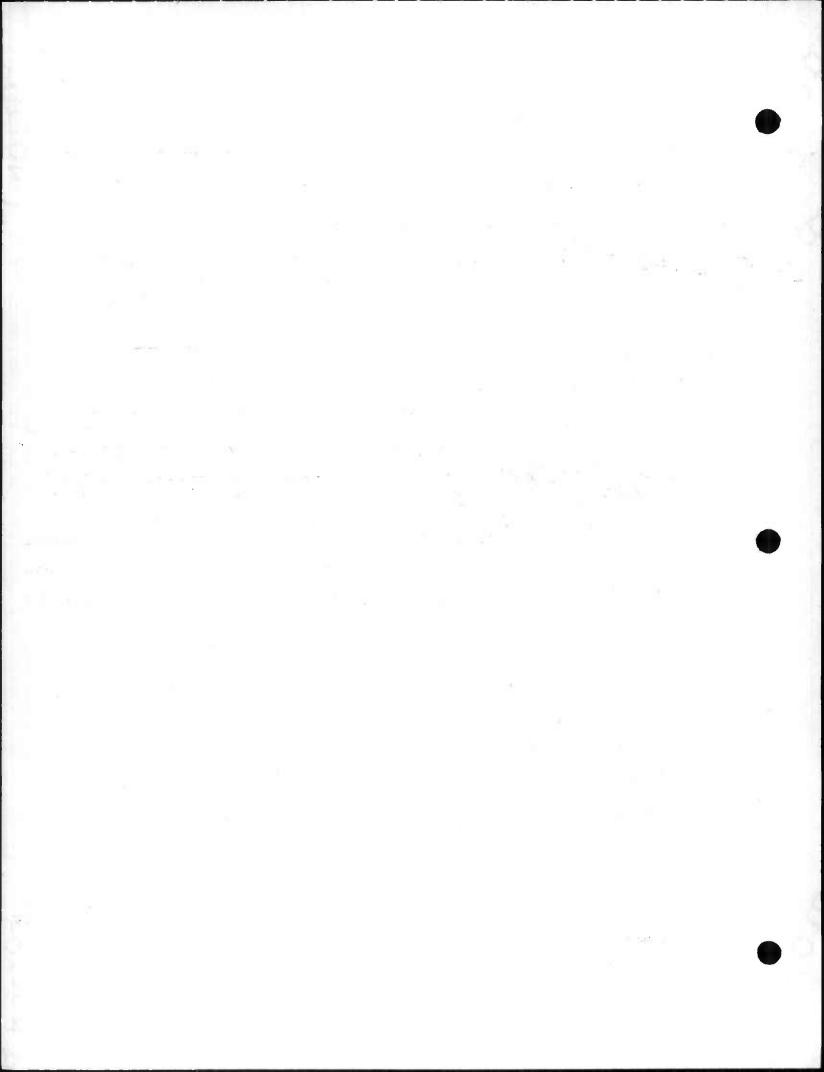
O1 27 216-16-2279 76 9a. FACILITY NAME (If not institution, give etreet end number 9b. CITY, TOWN OR LOCATION OF CEATN DIRECTOR HARBOR HOSPITAL CENTER Pages 1, 2, 3 BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION MARYLAND ANNE ARUNDEL GLEN BURNIE permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 7999 NOLPARK COURT-APT:101 21061 funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerlo Rican, etc.) 1 Never Merried 2 Married 1 YES 2 NO Specify BY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ET College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER 12 COMPL HOUSEWIFE 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First Middle Maiden Sumame Ħ CHARLES Z. CATTERTON GLADYS CATTERTON notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 CAROL A. OWEN 417 DUVALL LANE-ANNAPOLIS, MD. 21403 9 20e. METHOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must GLEN HAVEN CEMETERY GLEN BURNIE, MD. Donation 5 🗆 Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 2106 426 CRAIN HWY.S.W.GLEN BURNIE, MD. tal medical 23. PART I. Enter the diseases, or complications that ehock, or heart fellure. List only one cause sused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. on each line 6 IMMEDIATE CAUSE (FIRM the disease or condition METASTATIC OVARIAN CANCER resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): SMALL and com o burial, o OBSTRUCTION BOWEL traumatic CERTIFICATION Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING THROM BOSIS BEEP VEIN CAUSE (Disease or Injury other signed by the attending phy Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 - YES 2 NO shows a 50 has b. Dept. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Nome 5 | Residence 8 | Other (Specify) OR ATTENDING PHYSICIAN: 1 - YES 2 NO the 27. MANNER OF DEATN 28e. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED Migh 1 X Natural 1 YES 2 NO BY After death 2 Accident Investigation DIRECTOR: At hours after de item 28 is r 3 Suicide PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 6 Could not be determined 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 4 Homicide COMPLET 29e. CERTIFIER
(Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho 2 __ MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated. 29b SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Pltayest Jumpustarkul 244-1614 AS 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUMRUSSIRIKUL, HARBER HOSPITAL CENTER, 3001 SOUTH HANOVER ST PITAYADET

32. REGISTRAR'S SIGNATURE

Dhuch

DHMH-16 Rev 1/89



FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Migidle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ma 0,25 4. SOCIAL SECURITY NUMBER 7. DATE OF BURTH (Month, Day, Year) 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig 220 07 3062 1 M 2 X F 83 Dec. 22, Maryland Se. FACILITY NAME (If not institution oil 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Burne Arunde 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Riviera Beach 1 YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 244 Glen Road 21122 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES 2 TO NO Specify: BY 3 🔀 Widowed 4 🗌 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spi (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Home Maker Own Home Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 Raymond Page Mary Virginia Cummings BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Tingle Mary Tingle 10 Swampscott Court Baltimore, Maryland 21234 must be 28a. METHOD OF DISPOSITION
1 [X] Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Loudon Park Cemetery 4 Donation 6 Other (Specify) 5/22 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 merblish n and completely filled in by the to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition VASCULAR Ddayp ERETORD ACCIDENT event. reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): ATRIAL traumatic FIBRI LLATION CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immadiate the attending physician 1 Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 6 Injury. PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY Health and N 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE PERFORMED? апу UREMIA 1 YES 2 NO Shows OF DEATH? HMAERGILYKEMYA. 1 YES 2 NO t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) r this certificate h Item HOSPITAL:
1 Dinpatient 2 ER/Outpatient 3 DOA OTHER 1 TES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH marked. 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO After ti BY 2 Accident 28e. PLACE OF INJURY — Af home, farm, street, fectory, offica building, atc. (Specify) 99 ETED | 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: / 4 Homicide 28 determined hours Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the films, date end place, and due to the cause(a) and manner as stated. COMPL HOSPITAL E FUNERAL E within 72 h (Check only one) = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 296 EIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mo B OFFICER MBALAL HOWE > Wany 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NAH Ayoran. HOSF ITAL 301 DRIVE. GLEN RUR NIF 2106 MA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

. the second of the

REG. NO.

			1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH		3.	TIME OF DEATH
			Mary Hac	enbucher						- 1	May	H D	1995	YEAR	10.05
			4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yr	s. last birthday)	IF UNDE	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE	OF BIRTH			ACE (State or Foreign
			153 01 4697	1 🗆 M 2 🔽 F		78 YRS.	MONTHS	DAYS	HOURS	MIN.		h. Day, Year)	1917 N	Country)	
3	2008		9e. FACILITY NAME (If not institution, give :	street end number)		70	9b. CIT	Y, TOWN	OR LOCATI	ION OF DE		31,		Y OF DEAT	
6	י	R	Cherrywood Manor	Extended	Care	Center	Poi	etor	rtor.m					timo	
		ਹੋ	RESIDENCE OF DECEDENT		care								Bal	CTIIO.	re
Parair Dage	G C	DIRECTOR	10a. STATE 10b. COUNT			10c, CIT	Y, TOWN	OR LOCA	TION					10	d. INSIDE CITY
Ť.	i		Maryland Balti	more			Midd	lle F	≀iver					1	YES 2 NO
2	2	FUNERAL	10e. STREET AND NUMBER					10	. ZIP CODI	E			10g. CITIZE	EN OF WHA	T COUNTRY?
an.	0	Ä	10 Right Wing Dri							212	20		U.S	.A	
020 physician.		5	11. MARITAL STATUS 1 Never Married 2 X Merried	12. WAS DECEDEN FORCES? 1	YES 2	NO	13.	WAS DEC	ENDENT C	OF HISPANI	C ORIGIN	Y? (Specify Yes Ricen, etc.)	or No- 1	4. RACE Black, W	American Indian, filte, etc.
5-0020 nding physic		BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	Α.				Specify:		,		Specify:	
15- Itendi	3		15. DECEDENT'S EDU	CATION	160	DECEDENT'S	HSHAL C	VCCI IDATI	OM.		405	VIND OF BUI		0704	White
2121			(Specify only highest grade Elementary/Secondary (0-12)	completed)		(Give kind of life. Do NOT u	work done	during mo	ist of working	ng	160	. KIND OF BU	SINESS/INDU	SIMY	
D Spital		7	(?)	College (1-4 or 5 d	"	Hou	sewi	fe				HC	ME		
AND the hospit	once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)					_	18. MOTI	HER'S NAM	AE (First I	Middle, Meiden	Sumama)		
YL.	7	EC	Anthony Fis	ter						rrie		(?)	Surnemay		
MARYLAND 21215-0020 retained by the hospital or attending physician. S should be detached for use as the berislating	notified	00	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street e	and Number	or Rural A	oute Numi	ber, City or Tow	n. State. Zin C	inde)	
N e reta	2	2	James Poling			4061	Lewi	sbur	g Ro	ad F	inks	burg,	Maryl	and 2	21048
BALTIMORE, after death. Page 6 may be with funeral director, page	De la		20a. METHOD OF DISPOSITION		20b. PLA	CEANDDATE		_			DAT		CATION — CI		
ALTIMOR death. Page 6 ma	must		1 Description 2 Cremetion 3 Rem	oval from State		leigh				/19/	1		len, N		
P P	ner		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		-									abe _j
A L. Jeath.	i. examiner	9	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Eastern Ave. Baltimore, MAryland 2122												
BALTIMOF after death. Page 6 m by the funeral director.	removal.														
	or remova		shock, or heart failure.	List only one cau	se on aach	line.	not enter	r the mo	de of dyi	ing, such	aa card	diac or reapi	ratory arres	nt,	Approximata interval Between
3760 nted within hours completely filled in	ion, o		IMMEDIATE CAUSE (Fine)				1								Onset and Death
nith intervention	i, cremation, event, the		resulting in death)	a. Cerel	2000	010-	· 9	Sen	~						
68760 ecuted wit	al, ci			DUE 10	(OR AS A CO	NSEOUENCE O	F):								
5 Sec. 5	partie u	CERTIFICATION	Sequentielly list conditions,	b	(OR AS A CON	NSEQUENCE O	F)·								
G a F	rior t	¥.	if any, leading to immediate couse. Enter UNDERLYING		(011 110 11 00)	TOLOGENOE O	, ,.								
O. B. certificate ding physi	her p	임	CAUSE (Disease or injury that initieted events	cDUE TO	(OR AS A CO	NSEQUENCE O	F):								
O. Cert	and Mental Hygiene y Injury, or other	E	resulting in death) LAST	4											
S, P	ental	빙		d											
RDS at the d	th and Menta any injury,	A I	PART II. Other significant condition		death but n	ot resulting	in the u	nderiying	g ceuse g	given in P	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
OR that	5 6	EDICAL	U-195	hote;							_	1 TES 2		CO	MPLETION OF CAUSE
EC equires	shows	ME											•		YES 2 NO
TAL RECOR	with the State Dept. of rked, or Item 23 sho	ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF D	EATH YE	S 🗆	NO [UNC	ERTAIN	DA				,
VITAL HAN: The law	State D	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. P	LACE OF DEA			/		1				
OF VI. PHYSICIAN:	or H	YSI	1 TYES 2 NO	1 🗆 Inpatient 2 🗆	ER/Outpetien	n 3 □ DDA	OTHE 4 ☐ Nur		e 5 □ Re	sidence 6	□ Othe	r (Specify)			
OF PHYSICI	ed,	РНҮ	27. MANNET OF DEATH 1 Natural 5 Pending	28e. DATE OF (Month, De		26b. TIM	E OF URY	28c. INJ WO	URY AT		26d. DEŞ	CRIBE HOW II	NJURY OCCU	RED	
Z D NG P		B	1 Natural 5 Pending 2 Accident Investigation				М	1 🗆 1	/E\$ 2 [NO					
VISION ATTENDING CTOR: After	after de 28 Is	0	3 Suicide 6 Could not be	28e. PLACE Of building,	F INJURY — A atc. (Specify)	t home, farm,	street, lac	tory, office	•		261. LOCA	ATION (Street e	and Number or	Rural Route	Number,
	rs after		4 Homicide determined												
DI OHE		PLET	290. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge	, death occurr	ed at the t	lime, date	end place,	, end due t	o the cau	se(a) end man	mer es slated		
HOSPITAL	within 72 TANT: If	COM	one) 2 MEDICAL EXAMINE												d manner as stated.
5 5	be filed within 72 IMPORTANT: If		29b. SIGNATURE AND TITLE OF CERTIFIE							NSE NUME					onth, Day, Year)
D DE DE	MPOR	BE	Janlah)	the				ļ	70.	271		Į	> 5	1710	
pm pm	5 =	일	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH ((ITEM 27) (Type,	Print)			- ' '	- ,		- 1	115	,
7			Tick hower	- Jes	Man	- 55	R	ende	- +-	_ ~	0	2	1136		

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MAY 2 2 1995

DHMH-16 Rev 1/89

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH 3. TIME OF CEATH Has MONTH DAY

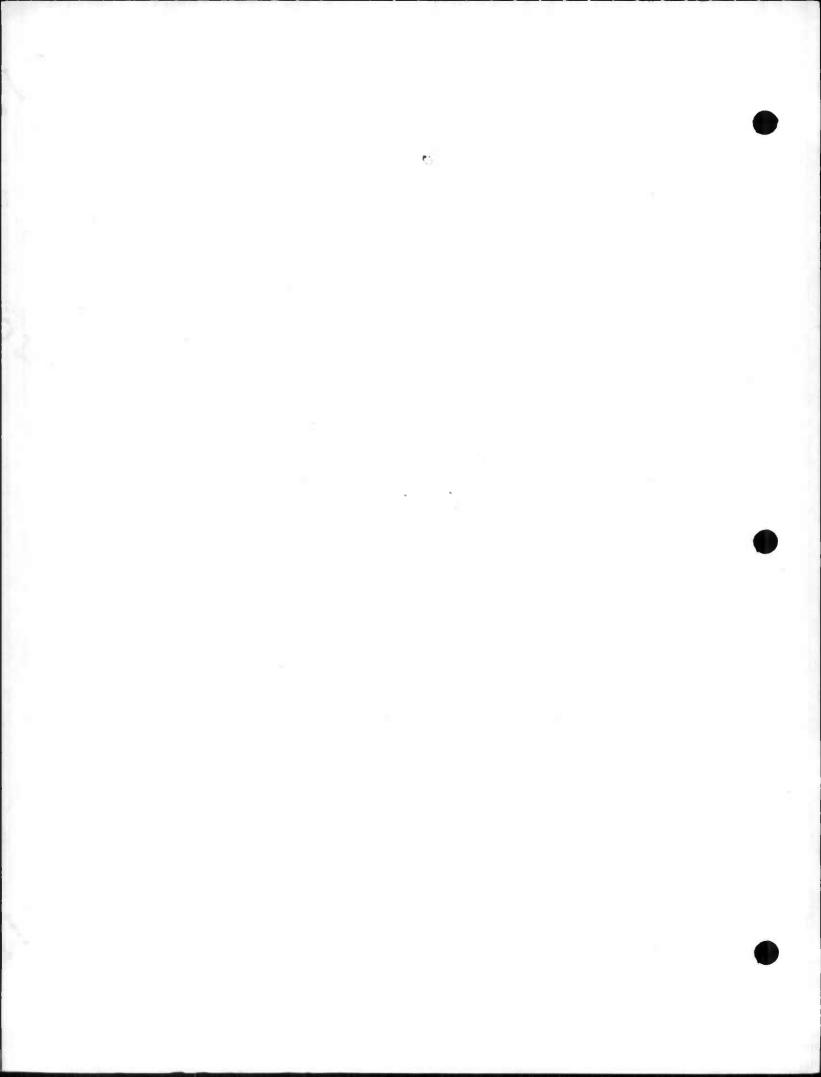
May 2/

7. DATE OF BIRTH

(Morth, Day, Year)

OCT-28-19/6 0800 AH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthe IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F MD Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ELIZABETH HOME BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNT 10d. INSIDE CITY LIMITS? 1 YES 2 NO 10c. CITY, TOWN OR LOCATION MD n/a BALTIMORE CITY permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1430 RICHARDSON STREET use as the burial-transit 21230 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOK IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TYES TO YES Specify BY Specify: WHITE 3 Widowed 4 Divorced ETED I 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify or page 5 should be detached for Elementary/Secondary (0-12) Callege (1-4 or 5+) COMPL OFFICE CLERK GLASS INDUSTRY 10 n/a 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ PETER HASPERT BE MAGDALANE RYANBACKER notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 PETER HASPERT 134 CLUB RD., PASADENA, MARYLAND 21122 death. Page 6 may be pe 20e, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must funeral director, Holy Cross Cemetery, May 24, 1995 4 Donation 5 Other (Specify) Baltimore, maryland examiner 21. SIGNATURE OF EUNERAL SERVICE LICENSPI 22. NAME AND ADDRESS OF FACILITY CHARLES L. SIEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MD 21230 been signed by the attending physician and completely filled in by the st. of Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceued the cent. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ahock, or haert failure. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Finel Possible disease or condition resulting in death) event, 24 hrs DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING HXY Chebroussular ACCI Det CAUSE (Disease or injury DUE TO (OR AS A CONSE that initiated events resulting in death) LAST 0 Injury, PART II. Other algorithms conditions contributing to death but not resulting in the undarlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL AWAILABLE PRIOR TO COMPLETION OF CAUSE any 1 TYES 2- NO OF DEATH? Shows 1 TES 2 500 has b. Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO DE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA me 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 1 Natural 28a. DATE OF INJURY this c 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. INJURY 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark 8 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL I -2 MEDICAL EXAMINER: On the beals of exa TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT: I nination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE AND TITLE OF CERT 29c. LICENSE NUMBER **BE** 495 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH JITEM 27/17/190, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 2 1995 Devoler

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completing filled in by the flument director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, committen, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Plage 6 may be making by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and componenty lifed in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to build, communant, or membral.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.	

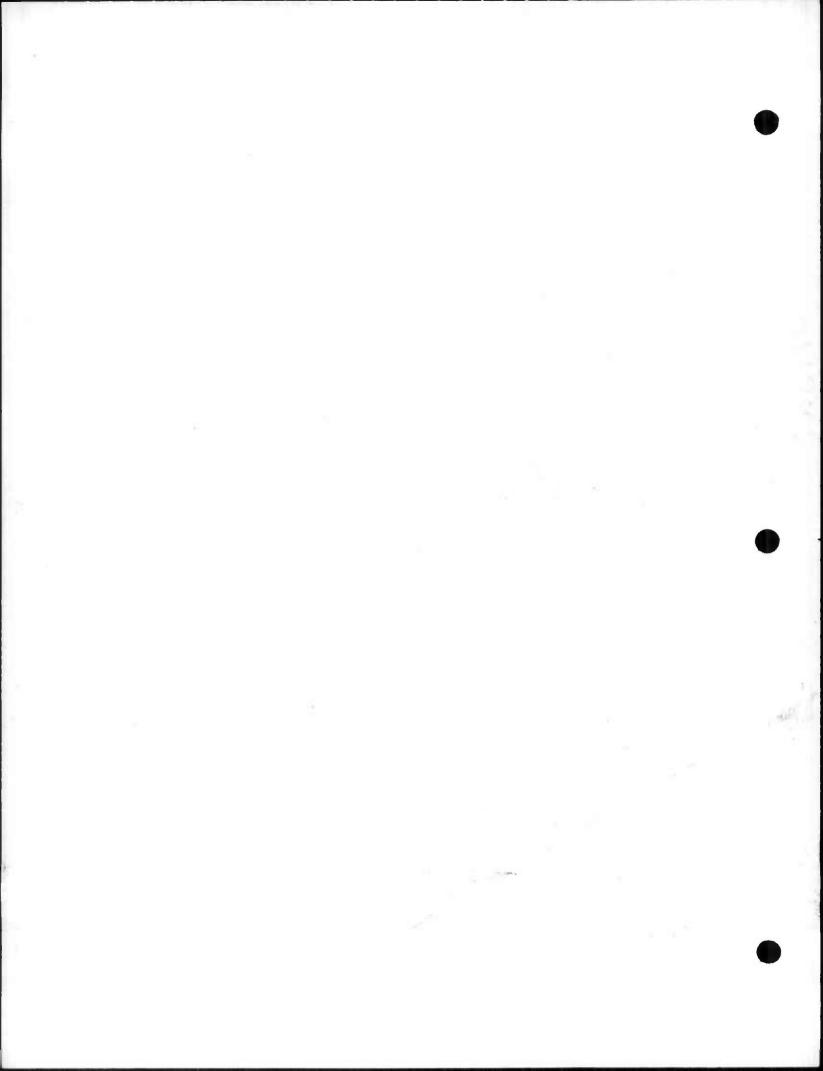
	1 - FOR STATE OF REGISTRAR	MARYLAND / DEPART	MENT OF HEALTH AND I	MENTAL HYGIENE					
1000000	1. OECEDENT'S NAME (First, Middle, Last) LEO R. HAN	SEN		2. DATE OF DEATH MONTH DAY AND DAY					
	4. SOCIAL SECURITY NUMBER 5. SEX 1X M 2 - F		IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) NEW JERSEY				
TOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF I RESIDENCE OF DECEMENT 9c. COUNTY OF I ANNE								
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND ANNE ARUND		TOWN OR LOCATION PASADENA		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 8232 FOREST GLEN DRI	VE	101. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
ВУ	1 Never Married 2 Married FORCES?	NT EVER IN U.S. ARMED 1 X YES 2 NO WAR OR DATES 1	13. WAS DECENDENT OF NISPAN If yes, specify Cuben, Mexicar 1 YES 2 NO Specify	, Puarto Rican, etc.)	or No— 14. RACE — American Indian, Black, White, atc. Specify: WHITE				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-4 or 5 0.4)	+) 16a. DECEOENT'S US (Give kind of wor COMMUN.	SUAL OCCUPATION A done during most of working TCATIONS OPERATOR	U.S.G	NESS/INDUSTRY				
BE CON	17. FATNER'S NAME (First, Middle, Last) ALFRED HANSEN			AE (First, Middle, Maiden S					
0	19a. INFORMANT'S NAME (Typo/Print) CAROL K. HEROLD		POREST GLEN D		State, Zip Code) ADENA, MD.21122				
	20. METHOD OF DISPOSITION 1 Method 2 Cremation 3 Removal from State 4 Donation 5 Other (Service Licenses) 21. SIGNATURE OF FURBILL SERVICE LICENSES	20b. PLACE AND DATE OF CARLINGTO	TANOITAN	5/25 ARI	ATION — City or Town, State LINGTON, VA.				
	· Lary L. K	Sufmons		FINK FUNI	ERAL HOME 21061 LEN BURNIE,MD.				
	23. PART I. Enter the diseases or complications the shock, or heart failure. List only one call MMEDIATE CAUSE (Final disease or condition resulting in death)	the state of the s	reino M.a.		atory arreat, Approximate Interval Batween Onset and Death				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST								
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINOINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DE DEATHS.								
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CA	AUSE OF DEATH YES 28. PLACE OF DEATN			1 YES 2 NO N/A				
IYSICI	EXAMINER? 1 YES 2 NO	□ ER/Outpatient 3 □ DOA 4	THER: Nursing Nome 5 Residence (
В	1 Netural 5 Pending (Month, i	FINJURY Day, Year) 28b. TIME C INJUR OF INJURY — At home, farm, stre	WORK? M 1 YES 2 ND	28d. DESCRIBE NOW INJ					
ETED.	4 Homicide detarmined	, etc. (Specify)		City or Town, State)	d Number or Rural Route Number,				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of medical examiner: Dn the basis of one of the control o	I my knowledge, death occurred a examination and/or investigation, in	at the time, data and place, and due t in my opinion, death occured at the i	to the cause(a) and menni lime, data and place, and	er as stated. dus to the cause(a) and manner as stated,				
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER		290. LICENSE NUM D39041	BER	29d. DATE SIGNED (Month, Day, Year) MAY 20, 1995				
-	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAL GAYATRI NIMMAGADDA M.			LTIMORE,	MD. 21225				
		R'S SIGNATURE							

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Uncortal to Afficient Exercise that the designation to action the designation of the control of	TO THE FUNEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hirtal-transft narmit in Panes 1.2.3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3.									
l	Richard John HURST		May 19 1995	2:26 P M						
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthde	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign						
	511-30-1190 1/2 M 2 □ F 61 YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year) Sept. 01, 1933	Country)						
	Sa. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF D		Kansas UNTY OF DEATH						
Œ										
DIRECTOR	FRANKLIN SQUARE HOSPITAL	Rossville	Da	ltimore						
Ĭ,	10a. STATE 10b. COUNTY 10c. C	ITY, TOWN OR LOCATION		10d. INSIDE CITY						
百	Maryland Baltimore Co.	Essex		LIMITS?						
A	10o. STREET AND NUMBER	101. ZIP CODE		TIZEN OF WHAT COUNTRY?						
FUNERAL	53 Rockywood Lane	21221		U.S.A.						
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Nover Married 2 Married FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes or No-	14. RACE American Indian,						
	IF YES GIVE WAR OR DATES	If yes, specify Cuban, Maxico	In, Puerto Rican, atc.)	Black, White, etc.						
BY	3 Wildowed 4 Divorced	X	,.	Specify:White						
E0	15. DECEDENT'S EDUCATION 16a. DECEDENT (Specify only highest grade completed) (Give kind of the kind o	'S USUAL OCCUPATION If work done during most of working	16b. KIND OF BUSINESS/IN	IDUSTRY						
<u>u</u>	FlementanulRecondary (0-12) College (1.4 or 5.) life. Do NOT	use retired.)								
NP I	CILIMI	ey Sweep	Cleanir	ng						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	16. MOTHER'S NA	ME (First, Middle, Malden Surname)							
BE (Unknown Unknown	Baldwi	in Unknown	1						
TO B	19a, INFORMANT'S NAME (Type/Print) 19b. MAILIN	IG ADDRESS (Street and Number or Rural	Route Number, City or Town, State, Zi	ip Code)						
🖹	Mrs. Mary J. Walker 53 R	ockywood Lane.Ess	sex. Maryland 2	1221						
	294. METHOD OF DISPOSITION 20h BLACKANDDAT	E OF DISPOSITION (Name of	DATE 200 LOCATION	Other and Towns Charles						
	4 Donation_5 Other (Specify)	allev Mem Gard	-23-95 Cockeys	ville Md						
- 8	21. BIGHATURE OF FUNERAL SERVICE LICENSEE JOFFWOY L GOY 22. NAME AND ADDRESS OF FACILITY									
	LEUNARD J. RUCK, INC.									
	22 DAUTA Experime disables as sometimes that	15305_Harford_F	Road Baltimore.	Maryland 21214						
	23. PARTA. Enter the diseases, or complications that caused the deeth. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, auc	h as cardiac or respiratory ar	Approximate Interval Between						
	immediate Cause (Final disease or condition resulting in death) a									
- 4	resulting in death) a									
8	Sequentielly Hat conditions, DUE TO (OR AS A CONSCOUENCE	ry po tanvion		20 20						
Ě	if any, leading to immediate									
일	CAUSE (Disease or injury	O.D.		2000						
Ē	and the desired to the second	OF):		1/						
CERTIFICATION	d. hypoxic									
<u></u>	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
DICAL	Gramie 67 Stead posible preunon	ie downter	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
MED	OF DEATH?									
≥	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
PHYSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA	OTHER:								
¥	27. MANNER OF DEATH 286. DATE OF INJURY 286. T.	4 Nursing Home 5 Residence ME OF 28c, INJURY AT	8 Other (Specify) 28d, DESCRIBE HOW INJURY OC	Milner						
	1 Natural 5 Pending (Month, Day, Year) II	WORK? M 1 YES 2 NO	200. DESCRIBE NOW INJURY OC	CORED						
ВУ	2 Accident Investigation 3 Suicide 5 Could not be 28e. PLACE OF INJURY — At home, farm		***							
8	3 Suicide 6 Could not be 4 Homicide determined	, street, sactory, office	26f. LOCATION (Street and Number City or Town, State)	or Rural Floute Number,						
H.										
COMPLETED	29a. CERTIFIER (Check only) one) Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
Ö	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.									
BE C	296. BIGHATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)									
	for the mark	1) 4019	5	5/19/5-						
2	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ									
ļ	Richard L. Penima, MD MD 50 Painters Mill Rd. Suite 6 Dwing Mills My 21117									
1	31. DATE FILED (MONIN, Day, Year) 32. REGISTRAR'S SIGNATURE	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								
- 11	. BRILLY 11 17 11 11 11 11 11 11 11 11 11 11 11			J						
	MAY 2 2 1995 Julia Standar Rank !!									



BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

95 15642 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MARY CATHERINE HOLDEN 11:25 am May 19 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest hirthday) S. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 215-03-1195 1 M 2 X 75 VRS 22. Oct. 1919 Maryland 9a. FACILITY NAME (If not institution, give atra 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center DIRECTOR Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? N/A Maryland Baltimore City 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3020 Christopher Avenue 21214 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, stc.)

1 □ YES 2 X NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married BY 3 X Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Soe ry/Secondary (0-12) College (1-4 or 5+) COMPL Acting Warden Baltimore City 12 Jail 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Thomas J. Eagan Catherine F. Mc Intyre BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Richard W. Holden 5315 Sherier Place N.W. Washington, D.C. 20016 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 M Burial 2 Cremation 3 L 4 Donation 5 Other (Specify) New Cathedral Cem. 5/23/95 Baltimore Maryland 21. SIGNATURE OF FUNERAL SERVICE I ICENSEE 22. NAME AND ADDRESS OF FACILITY Milton #J. Knight Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Md. 21214 23. PART I. Enter the diseasea, oc complications Enter the diseases, occomplications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximata Interval Between IMMEDIATE CAUSE /Final Onset and Death disease or condition METASTATIC SQUAMOUS CELL CARCINOMA OF THE LUNG 3 YEE resulting in death) DUE TO (OR AS A CONSEQUENCE OF): THROMBOSIS LEFT LIAC ARTERY 3 DYS. CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate HYPERTENSION cause. Enter UNDERLYING YRS. CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 10 OF DEATH? 1 TYES 2 PTWO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 TO OTHER: npatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year, 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural м BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 AERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursed at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D 25886

LILIA CEBALLOS, M.D., ST. JOSEPH MEDICAL CENTER, 7620 YORK RD., TOWSON, MD. 21204 32. REGISTRAR'S SIGNATURE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

296. SIGNATURE AND TITLE OF CERT

31. DATE FILED (Month, Day, Year)

BE

2

29d. DATE SIGNED (Month, Day, Year)

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TOTAL MARKET

THE TO THE WIND

shire Joseph Medical Center

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38885

LIUN DEBALLOS IN DE STELLOS EN LOS SEN MEDICAL DENTER 1820 YORK RO. TOWSON VO. 21 20A

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

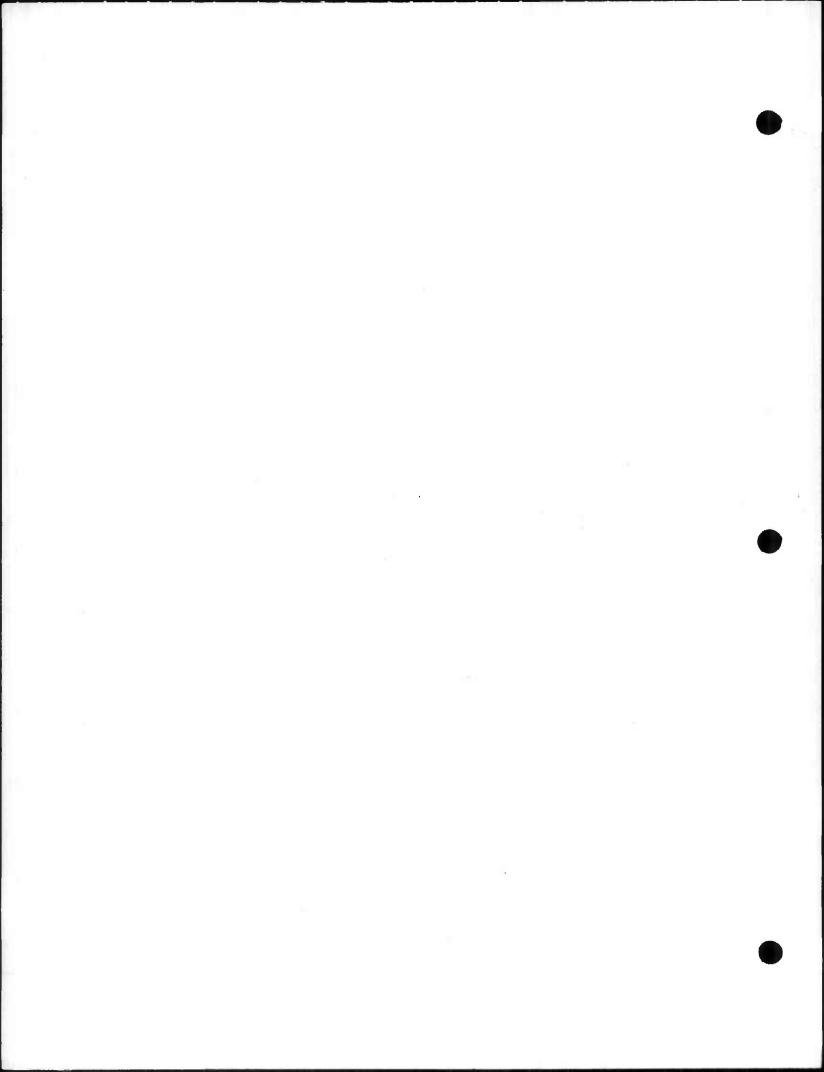
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

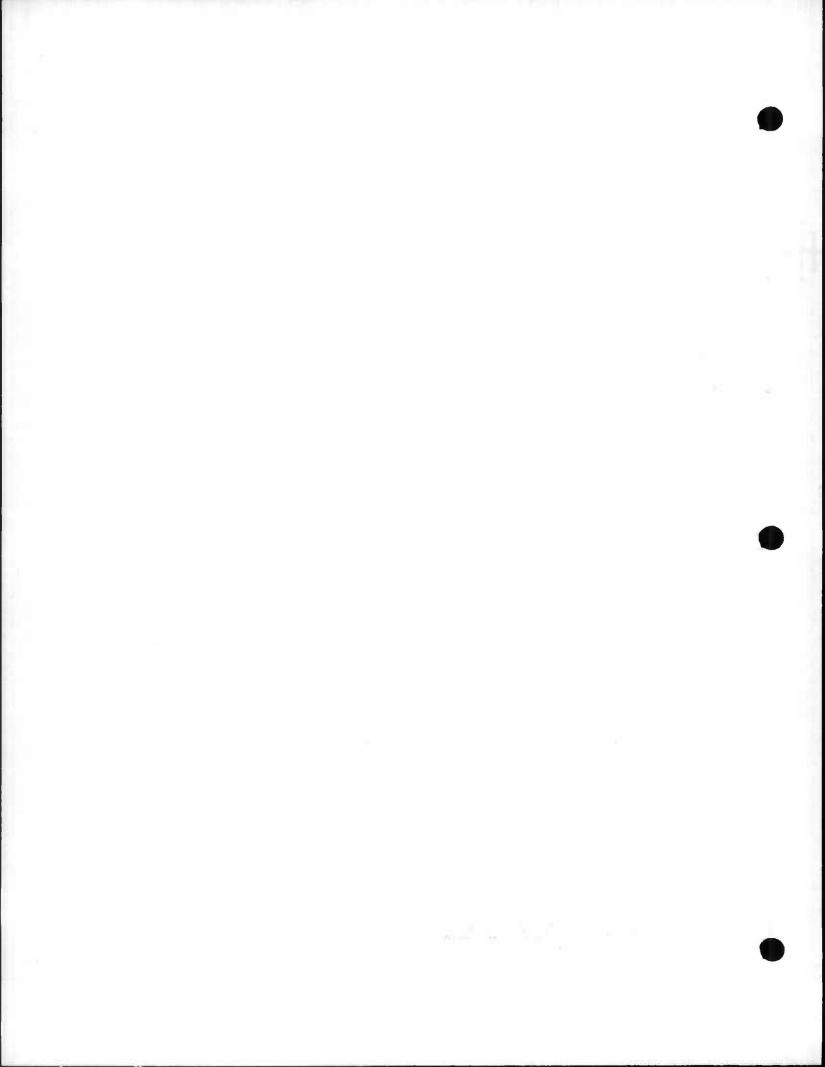
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)			2. DA1			TE OF DEATH 3. TIME OF DEATH			
		L. J	ackson		8 199	6:10 P. M				
	Activities and the second seco	I ONDER TYPER I ONDER ZERRIS. T. DATE OF BIRTH						BIRTHPLACE (State or Foreign Country)		
	233 48 2765 1 9a. FACILITY NAME (If not institution, give stree	YRS.		Ma	May 26, 1		West Virginia			
œ	Catonsville Nursi				OR LOCATION OF DE	ATH	9c. COUNTY OF DEATH Baltimore			
5	RESIDENCE OF DECEDENT	ing nome inc.	•	Cacon	SATITE		Dait	THOLE		
DIRECTOR	10a. STATE 10b. COUNTY		, TOWN OR LOCAT	ION	**		10d. INSIDE CITY LIMITS?			
LD	Maryland N/A 10e, STREET AND NUMBER	Ва	Baltimore			1 🔀 YES 2 🗌				
FUNERAL	2024 Whistler Av		101. ZIP CODE 21230				U.S.A.			
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AI			ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Sou			fy Yes or No.— 14, RACE — American Indian,			
ВУ Е	1 ☐ Never Married 2 ☑ Married FORCES? 1 ☐ YES 2 ☒ IF YES, GIVE WAR OR DATES				city Cuban, Mexicar 2 NO Specify	, Puerto Rican, atc.)	an, atc.) Black, White, atc. Specify:			
	15. DECEDENT'S EDUCAT	TION I	A DECEDENT'S	USUAL OCCUPATION	NA.	461 8810 05 011		White		
E	(Specify only highest grade cor	mpleted) College (1-4 or 5+)		ork done during mo:		16b. KIND OF BU	SINESS/INDUS	TRY		
AP.	12th	Order	Clerk		Paint	Compan	ny			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	werr Taglegon				AE (First, Middle, Maiden	Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	rry Jackson				ola Rumor				
임	William Folks			race Ave		oute Number, City or Tow Pasadena,				
	20a. METHOD OF DISPOSITION	20b. P		F DISPOSITION (Na		7				
	20b. PLACE AND DATE of DISPOSITION M Burlal 2 Cremetion 3 Removal from State									
	22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.									
	Janna M	1 France	oush	4001	Ritchie H	wv. Balt	imore.	Md. 21225		
	23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between									
	iMMEDIATE CAUSE (Fine) disease or condition									
	resulting in death) a									
_										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate but the form of the conditions of the condi									
2	CAUSE (Disease or injury									
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
	d									
SAL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? AM COM COM COM COM COM COM COM COM COM CO									
Ď	Dishet	W 2 20 1 1=	" and	uu		1 YES 2	NO	OF DEATH?		
Σ	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	DEATH VE	ПОП	LINICEDTAIN			1 TES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
VSIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)									
H	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORK?									
à l	2 Accident Investigation	4.1.	M 1 YES 2 NO							
	3 Suicide 8 Could not be 4 Homicide 8 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, offica City or Town, State)									
<u> </u>	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated.									
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and menner as stated. EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,									
BE	Sul Tourne D26256 > 5/19/							/ · · · · · · · · · · · · · · · · · · ·		
U 15	sun I bi	with			D2625	0	5/	19/95		
2	30. NAME AND ADDRESS OF PERSON WHO CO		H (ITEM 27) (Type, I	Print)			P 51	19/95		
ĭ	30. NAME AND ADDRESS OF PERSON WHO CO BICH T. DU 31. DAY AND 22 1995 Jul		2, 75	orine) Vas			, Ba	ltimore		



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			REGISTRAR		CERT	IFICATE OF	DEATH	REG.	NO.		
	į.		1. DECEDENT'S NAME (First, Middle, Last)		- 11 -			2. DATE OF DEAT	H		TIME OF DEATH
			ELVA COR	PRIVE ;)OHN-	5		\$ 3		YEAR I	11 48A "
			4. SOCIAL SECURITY NUMBER		(In yrs. leat birthde	77	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea			ACE (State or Foreign
	9		216-20-1361	1 🗆 M 2 🗔 🔀	74 YRS	3. MONTHS DAYS	HOURS MIN.	March 17	, 1921		land
	3 should		Se. FACILITY NAME (If not institution, give a	street end number)		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUN	TY OF OEAT	тн .
	2, 3	DIRECTOR	Carroll County	General Hosp	pital	We	Westminster Carroll				11
	← *	គួ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	v	10-	CITY, TOWN OR LOCA					
	Page			•	100.						Id. INSIDE CITY
	permit. Pages		Maryland Carr	oll County		Westmin	f. ZIP CODE				YES 2 NO
215-0020		ETED BY FUNERAL	16.5	Day!		10					AT COUNTRY?
	physician. burial-transit		21 Timber Ridge	12. WAS DECEDENT EVER	IN II S ADMED	140 990 050	21157			U.S.A	
	physic		1 Never Merried 2 Married	FORCES? 1 YES	1 YES 2 NO If yes, specify Cuben, Mex			n, Puerto Rican, etc	y Yee or No—	14. RACE — Black, W	American Indian, Vhite, etc.
	ging the		3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 U YES	2 X NO Specify	<i>t</i> :		Specify.	White
215	r attend use as		15. DECEDENT'S EDU (Specify only highest grade	CATION	16e. DECEDEN	T'S USUAL OCCUPATI	ON	16b. KINO OF	BUSINESS/INDU	JSTRY	
	50 0		Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NO	of work done during me T use retired.)	ost of working				
9	he hospita detached once.	4PL	12		V	Vaitress			Restau	rant	
BALTIMORE, MARYI		COMPLET	17. FATHER'S NAME (First, Middle, Last)				19. MOTHER'S NA	ME (First, Middle, Ma	iden Surneme)		
	8 & 8	TO BE	Herbert L. K	ane			Kath	ryn Barl	LOW		
	5 should notified		19e, INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADDRESS (Street	and Number or Rural I	Route Number, City or	Town, State, Zip	Code)	
	be n	-	Mrs. Kathryn And	erson	PCF	45 Box 5.	55 APO AF	EO 9468			
	> 0 0		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem			TE OF DISPOSITION (N	ame of	DATE 200	LOCATION - C	ity or Town,	State
	death. Page 6 ma tuneral director, p l. examiner must		4 Donation 8 Other (Specify)	00	oudon I	Park Ceme	tery 5/	25/95 I	Baltimo	re. M	arvland
	ral di		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME A	ND ADDRESS OF FA	CILITY			
	death. Particular of the formula of		HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400								
	after nova		23. PART i. Enter the diseeses, or	complications that cause	d the death D	Syke	esville,	MD 21/84	(410)	-/95-	
	3 2		snock, or neert isliure.	List only one cause on	esch line.	o not onto the me	de of dying, such	1 as cardiac or it	sepiratory sire	at,	Approximats interval Between
	7 filled tion, o									Onset and Death	
	ompleteh Crema event,	ł	disease or condition resulting in death) • CONG-ESTIVE HEART FAILURE Due to (or As A CONSEQUENCE OF):								
	and com o burial, c	_	_	HYDROPALS	VE COL	20.100	MCCHIA	D 1/10	BASE		YRS
9	and to bu	ERTIFICATION	Sequentisity list conditions,								
	siciar prior trau	AS	If any, isading to immediate cause. Enter UNDERLYING								
O. E	certificate ding physi tygiene pri r other to	Ē	CAUSE (Disease or injury that initiated events Due to (or as a consequence of):								
д. О		F	resulting in deeth) LAST	d.							
ภ์	the death y the atten od Mental H injury, or	O	PART II Other significant condition								
CORDS,		EDICAL	PART ii. Other significent condition	s contributing to deeth	but not resultin	g in the underlyin	g ceuse given in		AN AUTOPSY		ERE AUTOPSY FINDINGS AILABLE PRIOR TO
0	w requires that the been signed by pt. of Health and shows any li							1 _ YE	8 2 NO		MPLETION OF CAUSE DEATH?
H.	equir en si of He	Σ								1[YES 2 NO
	2 0 N	ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O			UNCERTAIN	1 🗆			
4	를 쓸 을 크	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:					
>	SICIAN: The Certificate the State	YS	1 TYES 2 1 HO	HopetTAL:	patient 3 DOA	4 Nursing Hom	e 5 🗆 Residence	6 Other (Specify)			
5	ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St.	PHY	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	286. 1	IME OF 28c. INJ	URY AT PRK?	28d. DESCRIBE HO	W INJURY OCCU	JRED	
Z	DING PHYS After this death with marked	À	2 Accident trivestigation	40			YES 2 NO				
200	OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farr icify)	n, street, factory, offic	•	28f. LOCATION (Str City or Town, S		r Rural Route	e Number,
5	OR ATT DIRECTI hours at	<u> </u>									
		COMPL	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated.								
		S	one) 2 MEDICAL EXAMINE	R: On the basis of examination	on end/or investiga	ntion, in my opinion, d	eath occured at the	time, date end place	, and due to the	ceuse(e) en	d manner ee stated.
		BE C	291 GIGNATURE AND TITLE OF CERTIFIER	A-	TPAIN	VNC	29c. LICENSE NUM	BER	29d. DATE	SIGNEO (Mc	onth, Day, Year)
1	MPOR	LI I	Chim 2 Ke	doro !	Hyeld	CALI	D211	22	15	121	195
		2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (7)	rpe, Print)		1			
	7		Arthur L. RUD	0, MD 90	4 LAS	HUGT	ON PR	WEST	25 M	ZR, 1	7 2115 7
	0		31. DATE FILED (Month, Day, Year)	20, REGISTRAR SIGN	ATURE						3
	L		MAY 2 2 1995 Ju	W IN INDICE LAND	44						
_											



BALTIMORE, MARYLAND 21215-0020

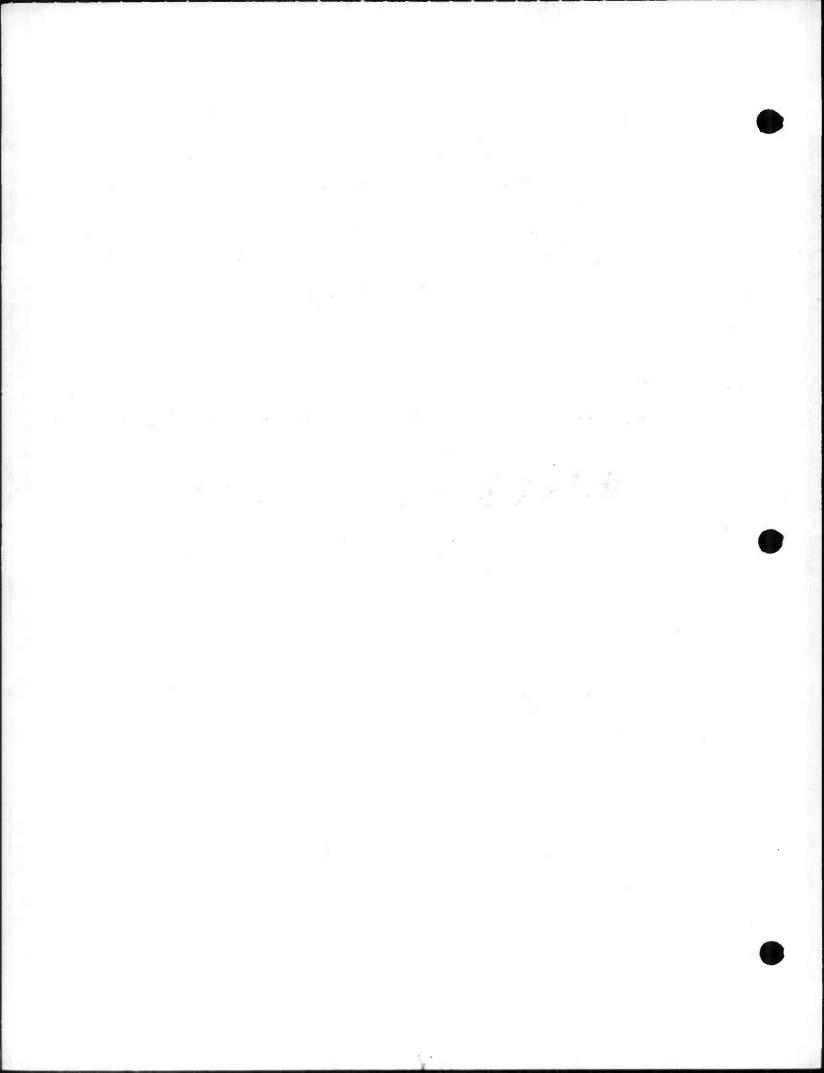
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours with death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the time function, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examinar must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTM CERTIFICA	ENT OF HE	ALTH AND N	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATN	
	Mary LaDean Ki:	sh				May 18,	1995 YEAR	9;30pm w	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs	s. (ast birthday) IF L	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		IPLACE (State or Foreign	
	220-03-9471 Se. FACILITY NAME (If not institution, give etra	1 □ M 2 😾 7:			LOCATION OF DE	(Month, Day, Year) September 9,1	1921 MD		
<u>«</u>	533 Annabel Ave	enue			nore Ci		9c. COUNTY OF O	N/A	
DIRECTOR	RESIDENCE OF DECEDENT			Daloin	1010	Ley		N/ A	
E	10a. STATE 10b. COUNTY	- /-		WN OR LOCATION				10d. INSIDE CITY	
		N/A	Ba	ltimor	ce City	7		YES 2 NO	
FUNERAL	100. STREET AND NUMBER 533 Annabel Av	venue		101. 21	IP CODE 212	225	10g. CITIZEN OF V	J.S.A.	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S.	. ARMEO	13. WAS OECEN		IC ORIGIN? (Specify Year			
BY F	1 Never Married XX Merried 3 Widowed 4 Divorced	FORCES? 1 Tyes 2 IF yes, give war or dates		If yes, specif	fy Cuben, Mexican KNO Specify:	, Puerto Rican, etc.)	Black	E — American Indian, k, White, etc.	
8	15. DECEOENT'S EDUCA	TION 16s	. DECEDENT'S USUA	AL OCCUPATION		16b, KIND OF BUSH	NESS/INDUSTRY	WIIICO	
E.	(Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work of life. Do NOT use retir	done during most o red.)	of working		12001111		
MPL	8th		Н	omemak	er	N/	A		
COMPLET	17. FATHER'S NAME (First, Middle, Last)					AE (First, Middle, Meiden Si	urname)		
BE	Harry Summers				Mary I	Defly			
2	19a. INFORMANT'S NAME (Type/Print)					loute Number, City or Town,			
-	Steve Kish					, Baltim	ore, MI	21230	
	20s. METHOD OF DISPOSITION 1 1 Ruriel 2 Cremation 3 Remov		CE AND OATE OF DIS				TION — City or To		
	4 Donation 5 Other (Specify)	Croy	nsvill	e VA c	emeter	y, May22	,1995	cownsville	
		1 () 17	7						
ш	A PUDDIO	CIME	1	1501 P	To and	7	D - 2 1 1	Home, Inc	
	23. PART I. Enter the diseases, or co- shock, or haert fallure. Li	mplications that caused the st only one cause on each	deast. Do not a	nter the mode	of dying, such	as cerdiac or reepira	tory arrest,	Approximate	
	MANERIATE DALIGE (E)		30.000	1.	, 1	<i>,</i> *		intarval Between Onset and Death	
	disease or condition resulting in death)	OUE TO GOR AS A CON atheroscler	ingestwe	2 hear	I tull	uve		2415	
		DUE TO (OR AS A CON	SEQUENCE OF):	400 1.	./.	v		10	
No	Sequentially list conditions, b.	DUE TO (OR AS A CON	OTIC YO	15CU las	r cliss	2450		10415	
EA.	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OH AS A CON	SECUENCE OF):					/	
2 ∥	CAUSE (Disease or injury that initiated events								
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RTIF	resulting in death) LAST	DUE TO (OR AS A CON	ISEOUENCE OF):						
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A	resulting in death) LAST d. PART ii. Other algorificant conditions	Contributing to death but no	of resulting in the	e underlying co	ause given in F	Part I. 24a. WAS AN AL		WERE AUTOPSY FINDINGS	
A	resulting in death) LAST	Contributing to death but no	ot reculting in the	uentia		Part i, 24a. WAS AN AI PERFORM	ED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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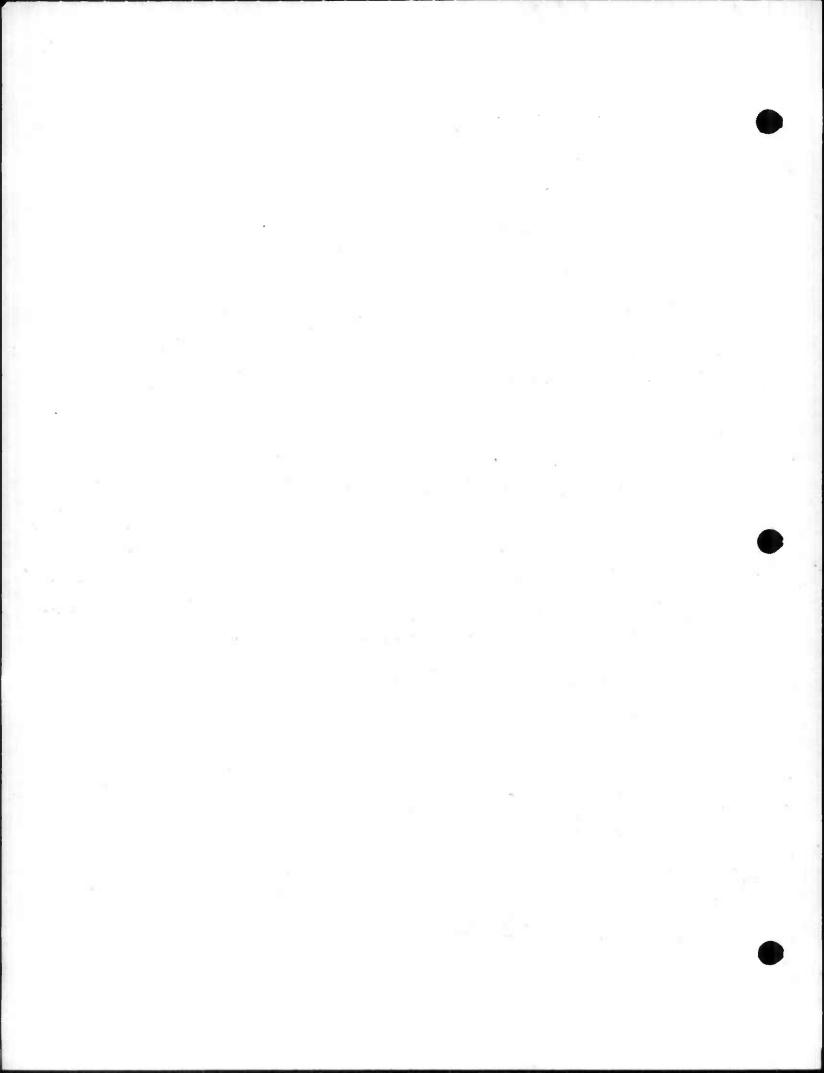
2. DATE OF DEATN

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		4. SOCIAL SECURITY NUME 218-14-0		5. SEX	6. AGE (In y		-	F UNDER 1 YEAR	IF UNDER 24	HRS. 7. I	DATE OF BIRTH (Month, Pex Year) DV . 10,	1003	Spyntry)	ACE (State or Foreign
pino		9a. FACILITY NAME (If not in			5.1		1000	b. CITY. TOWN	OR LOCATION			9c. COUNT		
.3 -28	NO N	98. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF N/A Baltimore N/A												
- S	DIRECTOR	RESIDENCE OF DECEDENT											Id. INSIDE CITY	
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t. Insit per	ERAL	9930 Windfl	ower D	rive				10	H. ZIP CODE	043			ISA	AT COUNTRY?
21215-0020 If or attending physician. For use as the burial-transit permit. Pages 1, 2, 3 should	BY FUN	11. MARITAL STATUS 1 Never Married 2 XXXIIII	T EVER IN U.S YES 2 MAR OR DATES						RIGIN? (Specify Your Property Rican, etc.)	es or No- 1	4. RACE — Black, W Specify:	American Indian, white, etc. White		
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	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)				Ille. Do	NOT use i	ered. N			Hospital/Heal			alth Care
2 2 2 K	ш	17. FATNER'S NAME (First, Middle, Lest) David Edward Coffman							16. MOTNE RU	r's NAME (I lfelle	First, Middle, Maide Koontz	n Sumeme)		
MA retain 5 sho	TO B	Ms. Pat Bur				196. M	930	Windfl	end Number of	Rural Route	Number, City or To	wn, State, Zip C	ode) Y, M.	D 21043
		20a. METHOD OF DISPOSITION COMMENTAL	n 3 🗆 Remo	oval from State				DISPOSITION (N		5/1		DCATION - CH	-	
BALTIMORE after death. Page 6 may by the funeral director, pa moval. ical examiner must t		21. SIGNATURE OF FUNGRA	L SERVICE LIC	EMSEE	0						Home, F	P.A.		
. 9 = -	\mathbf{H}	23. PART I/Enter the di	ilkillia	emplications that	t coursed th	M00					, Maryla			
tely filled in mation, or the me		shock, or hi	eart failure/	List only one cau	ae on each	iina.								
OX 68' be execute cian and cior to buria	CERTIFICATION	Sequenticily list conditi if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju	diata NG	0. 1	OR AS A CO		Coda Lacre							24 hr
P.O. B ath certificate trending physical Hygiene principle.	ERTIF	that initiated events resulting in death) LAS		MESENT	, .	6.4	nce of:	mís 2						15d.
DS, the dear of Menta injury,	- 21	PART II. Other eignifica	nt condition	a contributing to	deeth but i	not reeu	ilting in	the underlyin	ig ceuee giv	en in Part	I. 24a. WAS A	N AUTOPSY ORMED?		ERE AUTOPSY FINDINGS
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CC 2 8 7 76		DID TOBACCO U		RIBUTE TO CA	USE OF [DEATH	YES	□ NO [UNCE	RTAIN [
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OF V PHYSICIA this certif with the	PHY	27. MANNER OF DEATN 1 Netural 5	Pending	28e. DATE OF (Month, Da	INJURY		Bb. TIME (OF 28c, IN	JURY AT DRK?	280	I. DESCRIBE NOW	INJURY OCCU	RED	
NOING P. After the death is mar	ED BY	2 Accident 3 Suicide a	Investigation Could not be	28e. PLACE Of building,	F INJURY — i	At home,	ferm, stre	M 1	YES 2 1		LOCATION (Street City or Town, Stett	t end Number or	Rumi Routi	e Number,
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로 것 전 도	COMPLET	one) 2 MEDI	CAL EXAMINE	R: On the basis of ex										nd menner es stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	Maul Tata	264	Surgice	el 1C	41	Esio	Ent	1 .	O /		29d. DATE S	116/6/6	onth, Day, Year)
6		PETRITES,	M.D.	Stif	tones			coto	n Aue	В.	Eltinne	MD	217	39
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

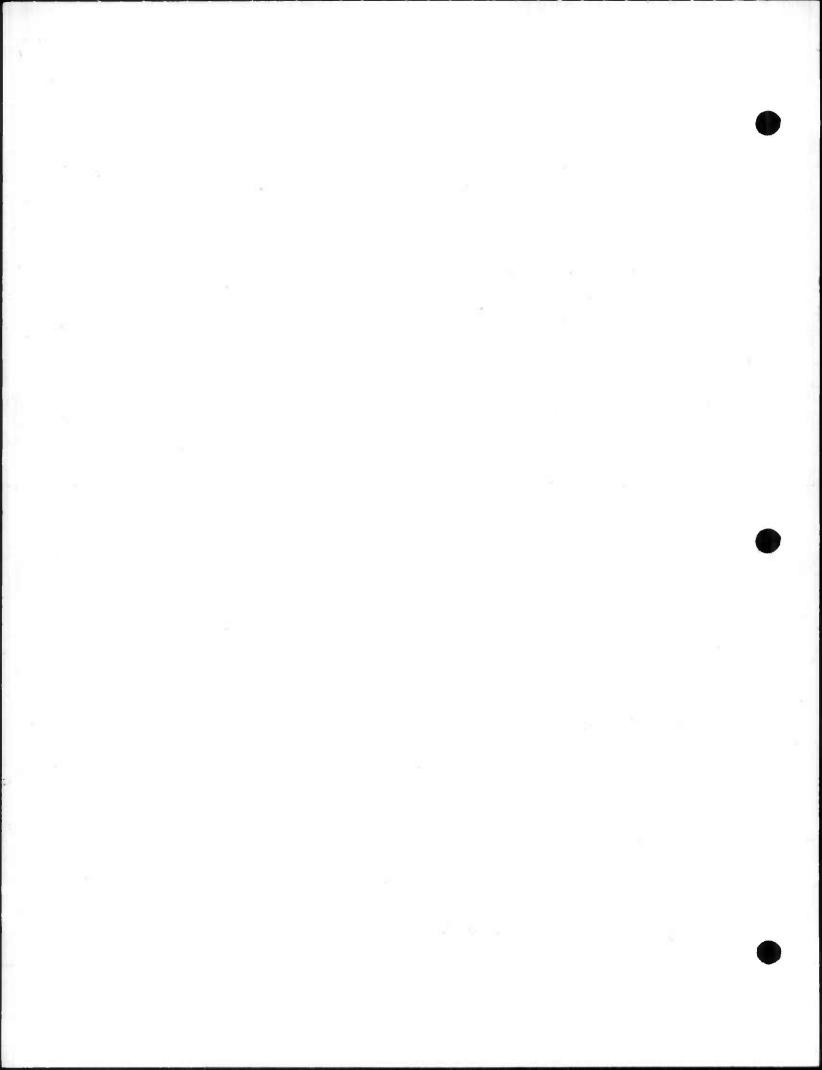
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)



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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	HEALTH AND	MENTA	L HYGIEN	E			
		1. OECEDENT'S NAME (First, Middle, Last)					2. DATE	OF OEATH		7EAR 3. 1	TIME OF O	EATH
			Cliford	Lee Kr	istal		May	13,	199		1:30	Рм
_			5. SEX 6. AGE ((In yrs. lest birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mont	of BIRTH h, Day, Year) e 27,	1947	BIRTHPLA Country)		
phouf		9e. FACILITY NAME (If not institution, give stre				OR LOCATION OF O	EATH	E 21,	9c. COUNTY		<u>ew Y</u>	OIK
1, 2, 3 should	CTOR	11215 Oakleaf I	Drive #420)	Silve	r Spri	ng		Mon	tgon	nery	
permit. Pages 1,	DIRE	Maryland Mon	tgomery		y, town on Locat ilver S					1 22	I. INSIDE C LIMITS? YES 2	Y
isi	IERAL	100. STREET AND NUMBER 11215 Oakleaf I	Drive #420)	101	20901			Unit			
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit	BY FUNE	1 Never Married 2 Merried	12. WAS OECEOENT EVER IF FORCES? 1 2 YES IF YES, GIVE WAR OR DE Vietnam, D	2 NO ATES	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexic 2 NO Speci	en, Puerto		or No- 14	Black, Wh Specify:	American in the otc.	
or attend	ETED	15. OECEDENT'S EOUCA (Specify only highest grade co	TION ompleted)	16a. DECEOENT'S	USUAL OCCUPATION	ON ost of working	166	. KIND OF BUS	INESS/INDUS		7111 0	
AND 2. The hospital of detached for	3	Elementary/Secondary (0-12)	College (1-4 or 5+)	Catalo	,			U.S.	Gover	nmer	ıt	
YLAN by the hos t be detach at nece.	i i ii	17. FATHER'S NAME (First, Middle, Last) J (ulius Kris	tal		16. MOTHER'S NA		Middle, Maiden Gould	Surname)			
be retained ge 5 should		Julius Krista:	1	19b. MAILING 1121	ADDRESS (Street e	and Number or Rural	Route Num	ber, City or Town	Silve	er Sp	orin	ą, MI
ORE of the state o		20a. METHOD OF DISPOSITION 1 Strain Burlel 2 Cremation 3 Remov 4 Donation 6 Other (Specify)	al from State cem	etery cremetory or o	of disposition (Na ther place) id Memo	rial Ga	15 oat		ation - ch	y or Town, 1	Stata	2.
ALTIM death. Page tuneral dir J. examiner		21. SIGNATURE OF FUNERAL SERVICE LICES	yare.		22. NAME AP	Pears	CILITY				. , ,	1.7
			chinsky	7	2847	Wilson	n Bl	vd.,	Arlin	ator	1, ² ₹	201 A
hours ed in or re		23. PART I. Enter the diseases, or conshock, or heart failure. Li	mplicationa that caused at only one cause on e	the death. Do i sch lina.	not enter the mo	de of dying, aud	ch ss care	flac or reapi	etory arrea	t,		imate Batween and Death
detely remati		disease or condition resulting in death) a.	Cancer of	the bi		rimary					10	mos.
2 5 7 6		Sequentially list conditions,	702 10 (011 70 7	. CONGLOGENCE O								
Se fe fe	CATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):							
certific refing pt rygiene	100	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):							
S, dear dear dear de arth	O	PART II. Other algnificant conditions	contributing to death b	ut not resulting	in the underlying	cause glven in	Part I	24a. WAS AN	LITOREY	DAY 1954	RE AUTOPS	V PRIDALOS
T and the	MEDICAL	None						PERFORI	MED?	AWAI	ILABLE PRI IPLETION O DEATH?	OR TO
requires requires of Healt shows	M	DID TOBACCO USE CONTRI	DUITE TO CALISE O	C DEATH VE	C C NO F	1 1111000000			(1 🗆	YES 2	NO
TAL The law ite has b ate Dept.	IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	Je 1	UNCERTAI	ΝЦ				41	14
F VITA SICIAN: The certificate the the State	Sic		HOSPITAL:	atient 3 DOA	OTHER:	e 5 K Residence	6 Othe	r (Specify)				
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UDING PHYS : After this c death with		2 Accident Investigation	26e. PLACE OF INJURY	At home town		YES 2 NO						
TTEN TOR: after	W I	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spec	ify)			City	ATION (Street er or Town, State)	nd Number or	Hurai Houte	Number,	
4 4 2 E	1 = 4		AN: To the best of my knowl On the beste of exemination							euse(e) end	l menner a	a stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE (29b. SIGNATURE AND TITLE OF CERTIFIER	L Heren	to m.	D	DOS S	MBER	_	29d. DATE SI	GNED (Mon	ith, Day, You	ar)
	10	30. NAME AND ADDRESS OF PERSON WHO S	COMPLETED CAUSE OF DEA	11 (TITEM 27) (Type, 800 Eye	Print)	NW #602	2, Wa	ashing	gton,	DC	20	006
6		MAY 2 2 1995	AREGETBAR FIG	TYPE								



OHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILEO (Month, Day, Year)

WAY 2 2 1995

22. REGISTRAR'S SIGNATURE

	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND /	DEPAR ERTIF	RTMEN	T OF H	IEALTH DEA	AND I	MENTAL HYGIEN			
	1. OECEDENT'S NAME (First,	Middle, Last)		7	-					2. DATE OF OEATH			3. TIME OF GEATH a
	ELMER	F.	LEON	NARD						MAY 19	f,]	.995	
	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs. les	st birthday)		R 1 YEAR		R 24 HRS.	7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	478-18-886	69	1X M 2 🗆 F	74	YRS.	MONTHS	DAYS	HOURS	MIN.	12 22	20	IO	WA
	9a. FACILITY NAME (If not ine					9b. CIT	Y, TOWN	OR LOCATI	ION OF OE	EATH	9c. COU	NTY OF D	EATH
OR											ARUNDEL		
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	•		T 400 CIT	TOWN.	27.1004						
NIN.	106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. INSIDE CLIMITS?												
	10e. STREET AND NUMBER						10	1. ZIP COD	\e		T 40. OIT	05 %	1 YES 2 NO
RA	207 HOLLY	MOOD	COURT				1		060			J.S.	WHAT COUNTRY? A.
FUNERAL	11. MARITAL STATUS	11002		NT EVER IN U.S. AR	MED	13	WAS DEC			NIC ORIGIN? (Specify Yes			
	1 Never Married 2 X		FORCES? 1	1 X YES 2 N	NO	- 8	If yes, sp	ecity Cubi	en, Mexica	in, Puerto Ricen, etc.)	I OF NO-		E — American Indian, k, White, atc.
BY	3 Widowed 4 Divon	roed	WW 11-	-KOREA			1 📙 100	2 Mu	Specify	/:		Specif	HITE
COMPLETED	15. DECE (Specify only	EDENT'S EDUC y highest grade	CATION completed)	(Ge	ECEDENT'S	work done	during mo	ON work!	Inc	16b. KIND OF BUS			
9	Elementary/Secondary (0-		College (1-4 or 5		Do NOT u	NAGE		rot or violi	ng.	ELECT MANU	RONIC:	TRIPT	NC
MP	1.2		04		האוין	NAGL	21/					LUIVE	NG
	17. FATHER'S NAME (First, Mich.) ELMER	iddle, Last) LEONA	ממי						HER'S NAI	ME (First, Middle, Meiden YOUNG	Surname)		
H	190. INFORMANT'S NAME (7/2		'KD										
2	MARCENE L	. LEO	ONARD	191	207	HOI	S (Street e	IOOD	CT.	Route Number, City or TowGLEN BU	n, Stete, Zic IRNII	E, MD	21060
	20a METHOD OF DISPOSITION NO. 1 DISPOSITION NO. 2 DISPOSITION S DISPOSITION OF DI	(specify)	- 6	20b. PLACE A certified by Creating MARY							CATION — OWNS		wn, Stata LE , MD .
	21. SIGNATURE OF FUNESAL	SERVICE LIC	ENSEE	1		1 00	A1414E 44	10	SS OF FAC				
	1	any	2.1	aufm	ever	RA 42	56 C	ND RAI	C. F	FINK FUNE VY.S.W.GI	RAL EN 1	HOM BURN	E ZIUGI
	23. PART I. Enter the dis	seeses, or c	complications the	it coused the de	eth. Do r	not enter	the mo	de of dy	ing, such	h aa cardlac or reapl	ratory an	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Fine			-	-								Onset and Death
	disease or condition resulting in death)	→	E	O OR AS A CONSEC	emi	~							10 Yeush
			DUE TO	(OR AS A CONSEC	DUENCE O	F):							Syeurs
No.	Sequentially list condition		b. IQ.	OF AS A CONSEC	ns /	dise	ase	1					yeurs
A.	If any, leading to immedicause. Enter UNDERLYIN	NG							_				3 months
SE	CAUSE (Disease or injury that initieted events		DUE TO	OR AS A CONSEC	DUENCE O	<i>ንቊ [</i> ዋ):	T91	IUVE	2				ומדמטרות כ
CERTIFICATION	resulting in deeth) LAST	r (. Car	retid o	athe	Mas	cle	matte.	d	1soase			2 4000
	DART II Other elepitices	- andition		11.7									1 - 7 - 010 7
SAL	PART II. Other eignificen	It conditions	a contributing to	death but not re	esulting	in the ur	nderiying	g ceuse g	given in i	Part I. 24s. WAS AN PERFOR	AUTOPSY IMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Ö										1 YES 2	(KNO		COMPLETION OF CAUSE OF DEATH?
Σ	DID TODACCO III	CE COLIE											1 YES 2 NO
AN I	DID TOBACCO US 25. WAS CASE REFERRED TO		RIBUTE 10 CA					UNC	ERTAIN	1 🗆			N/A
PHYSICIAN: MEDICA	EXAMINER?	MEDICAL	HOSPITAL:		E OF OEAT			x					
14S	27. MANNER OF DEATH		1 Inpatient 2 28a, DATE OF	ER/Outpatient 3	DOA 28b, TIM	-			esidence	6 Other (Specify)			
	1 Netural 5 P		(Month, D	ley, Year)		JURY M	28c. INJI WO	PRK?	NO	26d. DESCRIBE HOW II	NJURY OCC	CURED	
BY	2 Cutation	nvestigation	28e. PLACE C	OF INJURY — At hor	me farm.	etreet, taci)		100	281. LOCATION (Street e	and Alexandras	- Ormal D	
COMPLETED		Could not be setermined	building,	atc. (Specify)			W 91 W			City or Town, State)	NG NUMBOR	Or Pilures I'm	bute number,
٦	290. CERTIFIER TO YCERTIF	FYING PHYSI	CIAN- To the best of	browledge de	-ab account	d se the f	- dete	1 -100-	- 1	to the ceuse(e) end men			
₹ I										to the ceuse(e) end men time, date and place, and			- d
- 111	296, SIGNATURE AND TITLE O												
B	leffrer man	Jan C	D. O.	,				001	125	6 (Conn.)			(Month, Day, Year)
유	30. NAME AND ADDRESS OF I	PERSON WHO			M 27) (Type	Print)					M		19 ,1 995
							RMY	COM	MUN	ITY HOSPI	LTAL	-FŤ.	MEADE, MD.

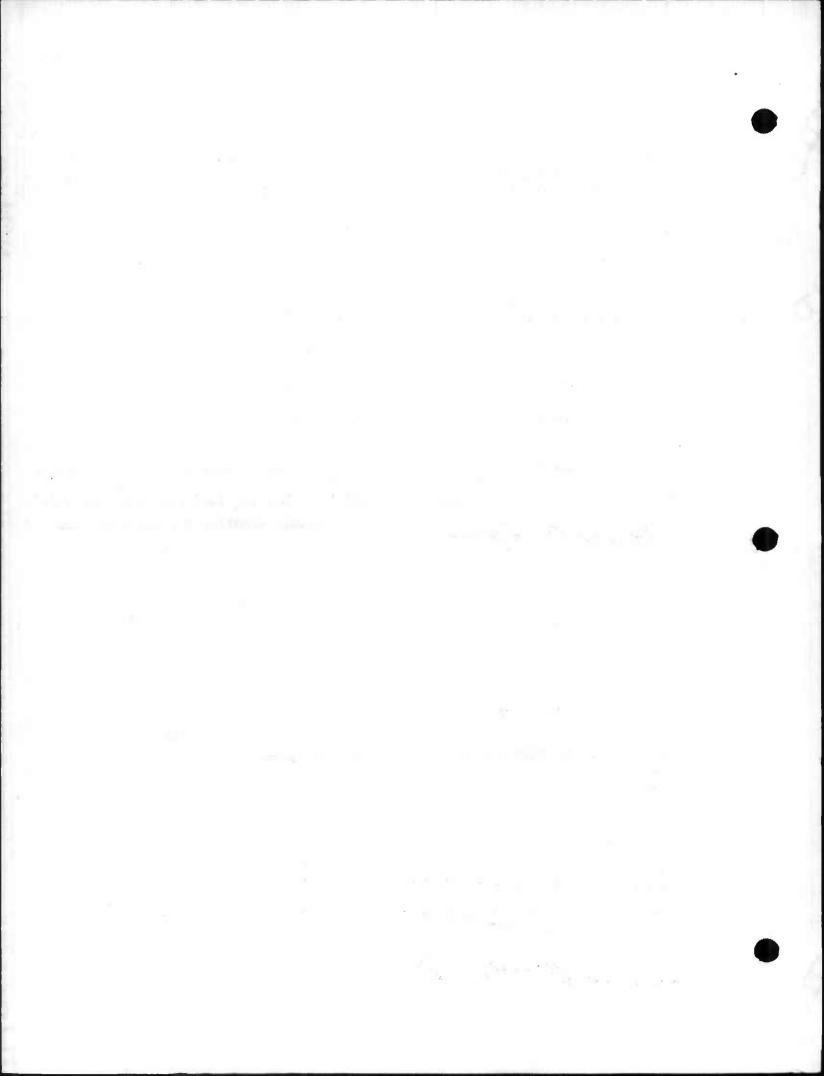
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the float of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTME ERTIFICA			MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Lest) Paula Lev					2. DATE OF DEATH MONTH 14,		3. TIME OF DEATN 10:00 A. M			
		SEX 6. AGE (In yrs. les 79	yrs. Full MONT	HS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Mouth, Day, Maer) Feb. 20,	A BIS	TNPLACE (State or Foreign intry) W York			
OR	99. FACILITY NAME (If not institution, give street and number) 4209 Underwood Street 99. COUNTY OF DEATN University Park 99. COUNTY OF DEATN Prince Georges										
DIRECTOR	10a. STATE 10b. COUNTY Florida Broway	rd	10c. CITY, TOV		ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL (100. STREET AND NUMBER 2851 Sunrise Lakes	Drive E. # 304			ZIP CODE 33322		10g. CITIZEN OF	WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Nover Married 2 Merried Widowed 4 Olvorced	P. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES AND IF YES, GIVE WAR OR DATES	IMED NO	If yes, sp	ENDENT OF HISPA Helfy Cuben, Mexico XX NO Specia	NIC ORIGIN? (Specify Y an, Puerto Rican, atc.) fy:	Bi	ICE — American Indien, ack, White, atc. ecity: 1TC			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade con Elementary/Secondary (0-12) 12 Years	npleted) (G	CEDENT'S USUA live kind of work do Do NOT use retire Bookkee	one during mo ed.)			usiness/industry				
BE COM	17. FATHER'S NAME (First, Middle, Last) Charles Forster				16. MOTHER'S NA Tillie	AME (First, Middle, Meide Juran	n Surname)				
TO B	190. INFORMANT'S NAME (Type/Print) Jerrold Levinson					Aoute Number City or To		, Md. 20782			
	20e. METHOD OF DISPOSITION VX Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	I from State Cemetery, or New Y	AND DATE OF DIS Vinatory, or other plu ION LETIC	ore	May	16, 1995		, New York			
	21. SIGNATURE OF FUNERAL SERVICE LICENS Ornald. C.	Stattlem	yer 2	TEIN 232 CA	HEBREW N	TEMORIAL F	UNERAL H	OME, INC. NGTON, D.C.			
CERTIFICATION	23. PART I. Enter the diseases, or com- shock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentiely list conditions, if sny, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	t only one cause on each line	QUENCE OF):	iter tha mo	de of dying, aud	th an cardiac or rea	piratory arrest,	Approximate intervel Between Onset and Death			
MEDICAL	PART II. Other significant conditions of DID TOBACCO USE CO					Part i. 24e. WAS A PERF(ORMED?	4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:			ACE OF DEATH (C)	heck only one)					
PHYSICIAN:	1 Ves 2 No 1	Inpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Year)		Nursing Nom 28c. INJ WO	URY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURED				
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJURY — At he building, etc. (Specify)	eme, farm, street,		'ES 2 □ NO	281. LOCATION (Stree City or Town, Stat		ni Route Number,			
COMPLET		N: To the best of my knowledge, de						e(s) end manner es stated.			
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	duque zn	m		294 PICENSE NU		29d. DATE SIGN	ED (Month, Day, Year) 5, 1995			
	Dr. Augusto P. Rod	iriguez POPURA	ıyburn (Court,	Camp Sp	orings, Ma	ryland 2	0748			
	31. DATE FILEO (Morth, Day Star)	32. HEGIŠTŘAR'S SIGNATURE	t _e								

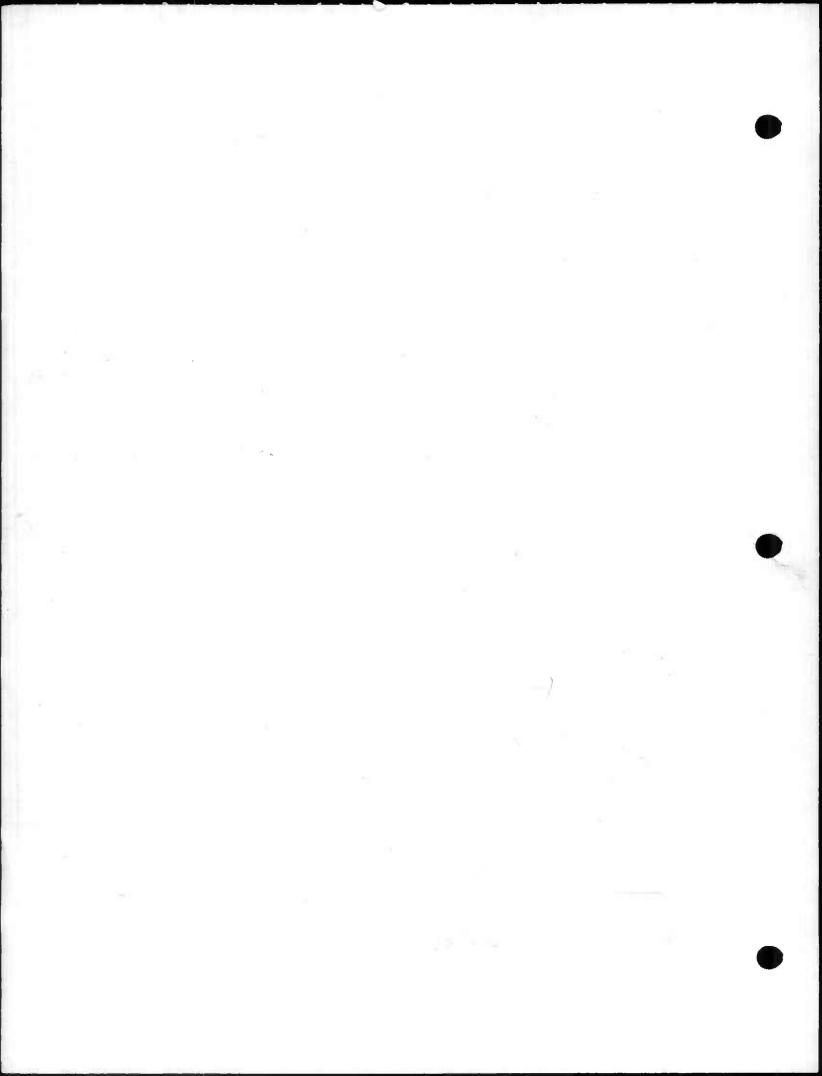


DIVISION OF VITAL RECORDS, P.O. BOX 68760

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	L DRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, should	2 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	filem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING A	TO THE FUNERAL DIRECTOR: After thi	be filed within 72 hours after death with	IMPORTANT: If Item 28 is mar

15650 95 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (FIRST	l, Middle, Last)		Mc	2003.0					2. DATE OF	DEATH	W	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUM	BER	5. SEX		rs. lest birthdey)	E 181	DER 1 YEAR	# 1810 m	3 64 LPM	1, 14.2	7	17	1995	01:40 H M
	212-28-54	190	1 □ M 2 🖾 🗶	86		MONTH		HOURS	MIN.	7. DATE OF (Month, L	Day, Year)	09	S. Country	CAROLINA
	9a. FACILITY NAME (If not in	nstitution, give s	street end number)			9b. CI	TY, TOWN	OR LOCATI	ON OF D		, -y		JNTY OF DE	
DIRECTOR	ST. AG	ENES	HOSPITA	L			BAI	TIMO	ORE	CITY		<u></u>	n/a	a
EC	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOW!	N OR LOCA	ATION						10d. INSIDE CITY
	MARYLAND		n/a					TIMO						LIMITS?
₹.	100. STREET AND NUMBER 7207 I			_			10	of. ZIP COD				10g. CI1	TIZEN OF W	HAT COUNTRY?
FUNERAL		NWOOL						212					ITED	SATES
BY FU	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	I NA	1	If yes, s	CENDENT C pecify Cuba S 2 AO	ın, Mexica	NIC ORIGIN? (in, Puerto Ric y:	Specify Yea an, etc.)	or No-	14. RACE Black, Specify	- American Indian, White, atc.
	15, DEC	EDENT'S EDU	CATION	16	a. DECEDENT'S	USUAL	OCCUPATI	ION		16b. K	IND OF BUS	INESS/IN	DUSTRY	BLACK
Щ.	Elementary/Secondary (0	ly highest grade D-12)	College (1-4 or 5 +	,	(Give kind of life. Do NOT u	work dor se retired	ne during m d.)	ost of working	ng	111/220				
린	6 TH		_		DISA	ABL	ED	LABO	DRER	:	PRIV	ATE	SEF	RVICES
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)						16. MOT	HER'S NA	ME (First, Mid	dle, Maiden	Sumame)		
ш	JERRY	LEST	ER						SAR	A				
TO B	19a. INFORMANT'S NAME (Type/Print)			19b. MAJLING	ADDRE	SS (Street	and Number	or Rural	Route Number,	City or Town	, State, Zi	(p Code)	
F	BETTE	BROC	KS		720	7	INW	100D	AVE	NUE,	BAL	rimo	DRE,	MD 21228
	20s METHOD OF DISPOSIT 1 D Burlal 2 Crematic 4 Donation 5 Other	on 3 🗆 Rem	oval from State	20b. Pt.	ACEAND DATE	OF DISP	OSITION (N	AL F	PARK	5-2	29c. LO	on, State		
	21. SIONATURE OF FUNERA	L SERVICE LIC	CENSEE ()					ND ADDRE						
j	Beman	d D	Johnso	21						FH				H AVENUE
	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart Isilure.	only one ceu	se on esch	e death, Do i				Ing, suc	h aa cardle	c or reapl	ratory sr	rest,	Approximata Interval Batween Onset and Death
CERTIFICATION	Sequantially list condition in sny, leeding to immecause. Enter UNDERLYI CAUSE (Disease or injusted interestated events resulting in death) LAS	diate ING Iry	b	(OR AS A CO	NSEQUENCE O	F):								
- 4	PART II. Other algnifice	nt condition	s contributing to	death but i	not resulting	In the	underlyln	g cause g	given in	Part i. 24	la. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL	m kneuzu	oma .	BUIN B	MB	Hyper	les	into	(9)	AA	A .	PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
	BIRVD				01				. , , , , ,	<u> </u>	YES 2	PA NO	- 1	OF DEATH?
Σ.	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF I	DFΔTH YE	S	NO F	7 LINC	FDTAI	<u> </u>				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO				PLACE OF DEA					* LM				
S	EXAMINER?		HOSPITAL:	ER/Outpatia	nt 3 🗆 DOA	OTH		no 5 🗆 Be	aldanas	6 Other (S				
	27. MANNEY OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF	_	JURY AT	INGOICE	28d. DESCR		JURY OC	CURED	
7		Pending Investigation	(Month, De	lly, Year)	INJ	M	1 🗆	YES 2	NO					
E	3 Suicide 8	Could not be determined	28a. PLACE Of building,	F INJURY — I	At home, farm,	street, fa	ectory, offic	ca		28f. LOCATI City or	ON (Street a fown, State)	nd Numbe	r or Rural Ro	oute Number,
COMPLE			CIAN: To the best of											and menner as stated.
- 11	29b. SIGNATURE AND TITLE							29c. LICE						
BE	Claude	ame	El ins	-	fende	ut	han.	19	~44			≥ 1/V	LOW	Month, Day, Year) 19, 1995
2	30. NAME AND ADDRESS OF KHIN MAUN			E OF DEATH	(ITEM 27) (Type,	Print) RNE	s Ho				bon Au	G, B	ALTIM	ORE, MD
	31, DATE FILED (Month, Day,	Year) L.	22. REGISTRA	R'S SIGNATUI										,



P.O.	
ECORDS,	
ITAL RE	
NOFV	
VISIO	
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_	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF I		MENTAL	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) HHENRY Meyer, Jr.	H. Henry	Meyer . J			2. DATE O	DAY	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	5-17-95	A BISTHEL	9:45 A ACE (State or Foreign
	219-10-9582 9a. FACILITY NAME (If not Institution, give st	1 M 2 D F	74 yrs.	MONTHS DAYS	HOURS MIN.	(Month,	3-15-21	PAN	AMA
5	1507 Charmuth Roa				or Location of D ithervill		9c. COU	Balti	
Š.	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY								
DIRECTOR		ltimore		ther L					INSIDE CITY LIMITS?
	10s. STREET AND NUMBER				OI. ZIP CODE		10g. CIT		YES 2 X NO
FUNERAL	1507 Charmuth Roa				210	93		U.S.	A.
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FDRCES? 1 X YI IF YES, DIVE WAR DF	ROATES	If yes, sp	CENDENT OF NISPA pecify Cuban, Maxico S 2 DND Specifi	en, Puerto Ric	(Specify Yes or No— can, etc.)	14. RACE — Black, V Specify:	American Indian, white, atc.
E	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPATI	IDN	16b. F	IND OF BUSINESS/IN	DUSTRY	110
MPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) -+3	We. Do NOT us	rork done during mile retired.) APACR/	Teacher	T	eacher	25	
BE COMPL	17. FATNER'S NAME (First, Middle, Last) HERMAN HENRY	r Meyer	SR.		16. MOTHER'S NA	AME (First, Min	Idle, Maiden Sumame)		
TO B	190. INFORMANT'S NAME (TYPE/PHINT) ANNE M CARTH	Y	196. MAILIND 1-5076	ADDRESS (Street	and Number or Rural	Route Number	; City or Town, State, Zij	p Code)	
	20a. METHDO OF DISPOSITION 1 Burlel 2 Cremation 3 Remo	oval from State	20b. PLACE AND DATE C	F DISPOSITION (Na	lame of	DATE	20c. LOCATION -	City or Town,	State
	4 Donation S Other (Specify)		METROCRE	MATORY	VD 4000000 05 50	5/18	BALTIM	ORC,	MARYLA
	919		-Sa.	AMBA 1328	EUSE FUR	NERA SPR	L. Home.	MA	TIMBRE, RYLAND 21227
	23. PART I. Enter the diseases, or consideration abook, or heart failure. L	omplications that cause on	sed the deeth. Do no each line.	ot enter the mo	ode of dying, auc	h aa cardie	c or reapiratory ar	reat,	Approximate Interval Between
9	IMMEDIATE CAUSE (Final disease or condition	0.1 .	was aw						Onset and Dea
	resulting in death)		mer's Dise						
z I	Sequentially list conditions,								
Ĕ	If any, leading to immediata cause. Enter UNDERLYING	DUE TO (DR A	S A CONSEDUENCE DF):					
RTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS	S A CONSEQUENCE OF):					
빙	DART II ON THE III	·							
SP.	PART II. Other algnificant conditions	contributing to deeth	but not reaulting in	n the undarlyin	g cause given in		44. WAS AN AUTOPSY PERFORMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO
MEDIC						- 1	TYES 2 ND	DF	DEATH?
Z	DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YE	S NO C	UNCERTAIL	N 🗆		1 ''	YES 2 ND
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE DF DEAT	H (Check only one) OTHER:					
HYS	1 VES 2 ND 27. MANNER OF DEATH	1 Inpatient 2 ER/O		4 - Nursing Norr	ne 5 XRaaldence		100		
BY P	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year	r) INJU	M 1 🗆	YES 2 NO		OC YRULNI WON BBIF		
ETEG	3 Suicide 6 Could not be 4 Nomicide detarmined	building, etc. (S)	RY — At home, farm, st pec/ly)	treet, factory, offic		28f. LOCAT	ON (Street and Number Town, State)	or Rural Route	Number,
	29e. CERTIFIER (Check only one)	EIAN: To the best of my knot: On the basis of examinat	owledge, death occurre	d at the time, date n, in my opinion, d	end place, and due death occured at the	to the ceuse time, data ar	(a) and menner as stated place, and due to the	led. ne cause(s) an	d manner ea stated.
OMPL	2 MEDICAL EXAMINER				29c. LICENSE NUM	#BER	29d DAT	E SIGNED (Ma	ontif. Day, Year)
	2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE DF CERTIFIER						2001.071		Carl rout
	296. SIGNATURE AND TITLE DF CERTIFIER	ww			0241	49	Þ E	5/17	195
		completed cause of a	DEATH (ITEM 27) (Type,	Print) 10 N. Gr	0241	49 , Bal	► E	5/17	195

hours after d

executed

death certificate be

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OR ATTENDING PHYSICIAN:

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lust) 2. DATE OF DEATH 3. TIME OF DEATH Carroll MASSON 1995 May 19 7:30 AM 4. SOCIAL SECURITY NUMBER 8. AGE (In vrs. lest birthdev) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign Maryland 214-26-4076 1 X M 2 | F 65 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give alreet and number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3512 Fleet Street City Baltimore City RESIDENCE OF DECEDENT 10c. CITY TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY N/A Maryland Baltimore City 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3512 Fleet Street funeral director, page 5 should be detached for use as the burial-transit 21224 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify Specify: BY 3 Widowed 4 Divorced 1951-1953 White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or S+) Oiler Sugar Factory N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Masson 75 BE Pearl notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward Frank 3512 Fleet Street Baltimore, MD 21224 pe 20a. METHOD OF DISPOSITION
1 (X Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must woodlawn Cemetery 5/22 4 Donation 5 Other (Specify) Baltimore, MD 21 SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Homes 700 S. Conkling Street Balto., MD 21224 atherine in and completely filled in by the 1 to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Between **Onset and Death** IMMEDIATE CAUSE (Final have been Sudden mi I. disesse or condition_ MUKROWIL, event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF traumatic AD5 CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE if sny, leading to immediate cause. Enter UNDERLYING been signed by the attending physician it, of Health and Mental Hygiene prior to R CAUSE (Disease or injury other A CONSEQUENCE OF that initiated events reaulting in death) LAST 6 PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO [has be Dept. 23 2S. WAS CASE REFERRED TO MEDICAL DEATH (Check only one) EXAMINER? certificate h the State 1, or Item HOSPITAL: Inpetient 2 - ER/Outpetient DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 286. TIME OF 28c, INJURY AT 26d. DESCRIBE HOW INJURY OCCURED this c. marked, 1 Natural Accide 1 YES 2 NO DIRECTOR: After the hours after death BY Investigation Accident 3 Sulcide 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be COMPLETED 4 Homicide 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. TO THE HOSPITAL O
TO THE FUNERAL D
DE filed within 72 ho
IMPORTANT: If 14

ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D243

31. DATE FILEO (Month, Day, Year) MAY 2 2 1995

29b. SIGNATURE AND TITLE DF CERTIFIER

some

Dr. Mukesh Luhar

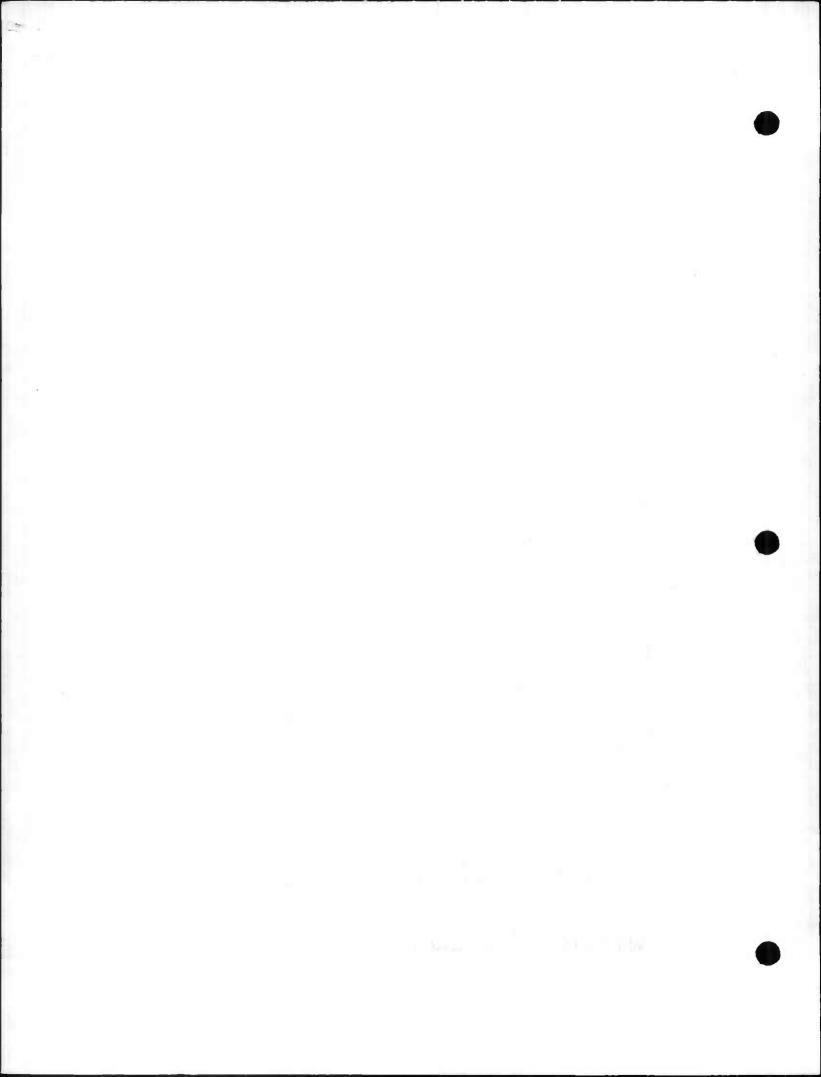
MEDICAL EXAMINER: On

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

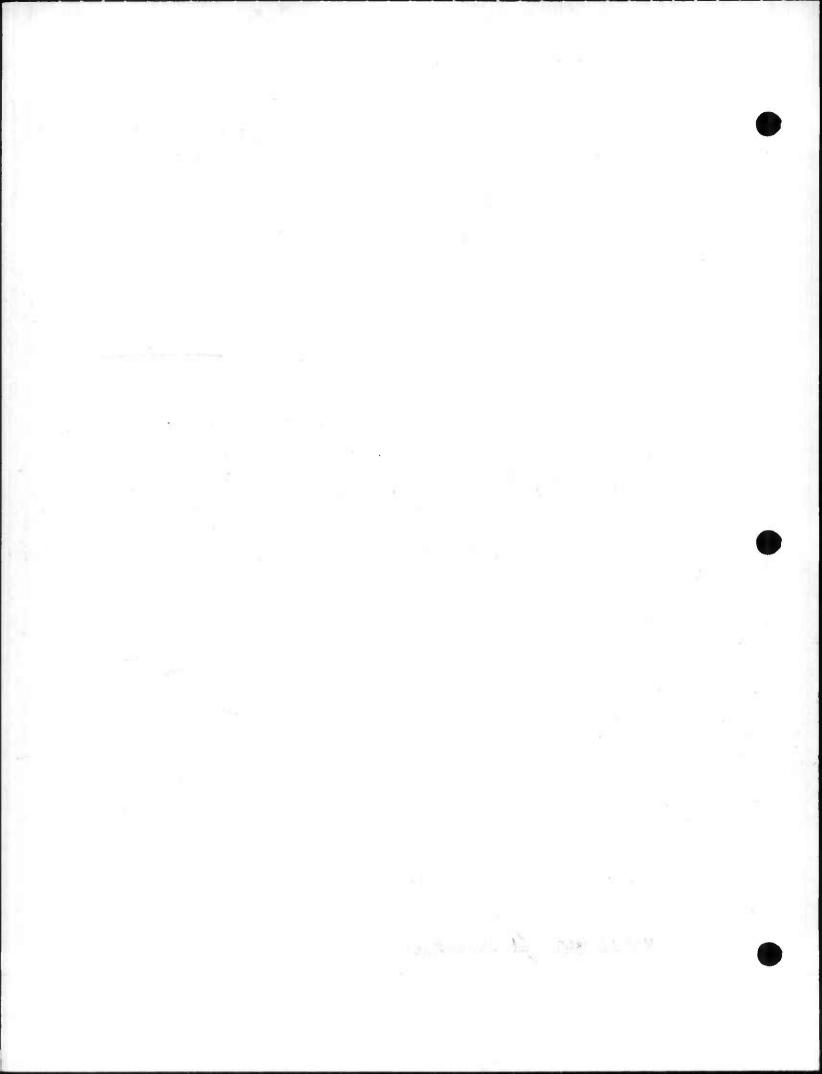
32 REGISTRAR'S SIGNATURE

3509 Eastern Ave. Baltimore, MD 21224

29d. DATE SIGNED (Month, Day, Your)



			1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT OF I	HEALTH AND	MENTA	AL HYGIEN				
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9			216-16-6585	1√□ M 2 □ F	74 YRS.	MONTHS DAYS	HOURS MIN.	SE.	e of Birth hth, Day, Year) PT.9,]	1920 T	VIRG		/
2. 3 should		CTOR	9e. FACILITY NAME (If not institution, give st TRINITY GERIA		R	96. CITY, TOWN	OR LOCATION OF I	DEATH		BALT			
SS →		LLI I	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c C	ITY, TOWN OR LOCA	TION					Id. INSIDE CITY	_
permit. Pages		L DIRI	MARYLAND N	/A		BALT	IMORE C	TTY			1	LIMITS? YES 2 NO	
is.		FUNERAL	1001 ABBOTT CT			10	f. ZIP CODE	120	2		OF WHA	T COUNTRY?	
5-0020 nding physician. is the burial-transit		BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, OIVE WAR OR D	2 J NO	if yea, sp	CENDENT OF HISPA Hecity Cuban, Maxie 2 NO Spec	can, Puarto	IN? (Specify Yes Rican, atc.)		RACE -	American Indian, Vhita, atc. BLACK	
r attending use as the		ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT	S USUAL OCCUPATION	ON	16	b. KIND OF BUS	SINESS/INDUS	TRY		_
21 Solution		IPLET	Elementary/Secondary (0-12) 6 TH	College (1-4 or 5+) N/A	life. Do NOT	work done during me use retired.) FINISH			CONSTRU	CTION	HON	F CO	
The hospi	ouce	COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First,			1011		_
2 2	# P	ш	JAMES MAYO				LUC	INDA	A HEND	RICKS	5		
MAR retained 5 should	notified	TO B	19a. INFORMANT'S NAME (Type/Print)			O ADDRESS (Street I			nber, City or Town	n, State, Zip Co	de)		
- 8 8	be no	- 1	VAN MAYO		10	001 ABBO	OTT COU	RT	BALTO	,MD.	21	202	
E C S			20a. METHOD OF DISPOSITION **D Burlel 2	rval from State Cerr	netery, cremetory or	EOF DISPOSITION (Ne		DA		CATION — City			
Page 6 m director.			4 Denetion 5 Other (Specify)	Inches ()	KING ME	MORIAL	PARK ND ADDRESS OF F	5/27	7/ 9 5 B	ALTO,	MD		
death. Pag tuneral di l. examiner	amin		[]	X	-1 /	CALVI	IN B. S	CRU	GGS FU	NERAL	. но	ME	
ter de	69	_	Causa L) · *+CVMON	M.AI	1412	E. PRE	STO	ST.	BALTO	, MD	.21213	
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ted within completely	f, cremation, event, the		resulting in death)	DUE TO (OR AS A	STAGE	RENAL	DISET	SE				ZMONT	ps.
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× 8 6	rior to buri	CATION	Sequentially list conditions, if eny, leading to immediate	DUE TO (OR AS A	CONSEQUENCE	OF):							_
ste be	α,	8	cause. Enter UNDERLYING CAUSE (Disease or Injury										
ng Ph	other other	RTIFI	that initiated events	DUE TO (OR AS A	CONSEQUENCE	OF):							_
death certificate attending physic		SER	resulting in death) LAST										
9 6	를 흘	AL C	PART II. Other significant conditions	contributing to death b	ut not resulting	In the undarlying	g cause given in	n Part I.	24s. WAS AN		24b, WE	RE AUTOPSY FINDING	as
E # E	20 000	EDIC							PERFOR	_	co	AILABLE PRIOR TO IMPLETION OF CAUSE	
quires the	shows	ME								(a)		DEATH?	
aw requ	2 C	AN	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH Y	ES NO [UNCERTA	IN 🗗	†			3 .20 2 3	
has has	item 2	S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE	ATH (Check only one)							
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PHYSICIAN: this certifica		PHX	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TI		URY AT	26d. DE	SCRIBE HOW IF	NJURY OCCUR	ED		
NG P	marked	B⊀	2 Accident Investigation	P//\	N		YES 2 NO		^	//\			
L OR ATTENOING P. L. OIRECTOR: After 1	28 is		3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	street, factory, offic		28f. LO	CATION (Street a or Town, State)	nd Number or F	fural Floute	Number,	
OR AT	Item 2		29a. CERTIFIER			V/PI				N//\			
45	N 900	COMPL	(Check only	CAN: To the best of my knowl									
HOSPITAL	ANTI	ဗ		t: On the basis of examination	and/or investigat	ion, in my opinion, d	eath occured at the	e time, dat	a and placa, and	d due to the ca	ruse(a) an	d manner as stated.	
불뿔	흥토!	H H	29b. SIGNATURE AND TITLE OF CERTIFIER	DV12	00		29c. LICENSE NU	MBER	, 7	29d. DATE SI		onth, Day, Year)	
2 2	2 ₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM OF C	a Brint)	145	93		F 3"	<i>- a</i> a	-27	
11			7770 Pag	K 12 - of to	S Ave		16.9	1	717/	720			
		ŀ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	2 1170	. 00	1 2. 4	11)	2120	20	_		_
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e be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not not burial cremation, or semanal	The second secon
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the death cer	the attendin	

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PLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

KOREUWO. 1

111 Penn Street, Baltimore, Maryland 21201

to william, 700 A

be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	
iled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or PORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the me	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hou TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled is	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29a. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my kno

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	1 - FOR STATE REGISTRAR		STATE OF M		DEPAR ERTIFI					MENTA	L HYGIEN REG. NO.	E			
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	4. SOCIAL SECURITY NUME			8. AGE (In yrs. les	st birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH	-	a Dinne	PLACE (State or	
	141-22-37		1 M 2 XF	65	YRS.	MONTHS	DAYS	HOURS			2 13, 1				ey
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CTO	RESIDENCE OF DEC	EDENT						Daa				11011			
RE	Moserel and	10b. COUNTY			10c. CITY									10d. INSIDE CI'	
LD	Maryland	Monte	jomery		51.	rver		rin						1 YES 2	
ERA	4 Fulham (Court					101	209				1.0	S.A.	VHAT COUNTRY	
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 X	RMED	1	f yes, sp	ENDENT O	n, Mexice	n, Puerto	N? (Specify Yea Rican, etc.)	or No-	Black	American In k, Whita, etc.	
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COMPLETED	Elementary/Secondary (C		College (1-4 or 5+)		ive kind of w Do NOT use	,	zumg mo	SE OF WORKE	w.		l				
ME	17. FATHER'S NAME (First, M	Iddle Leet		HOI	memal	ker					own h				
	Israel Ha										Middle, Melden				
BE	Israel Harris Miriam Gottlieb 19a. IMFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
2	Eli P. March 4 Fulham Court, Silver Spring, Md. 2										20902				
	20a. METHOD OF DISPOSIT Durial 2 Crematic Donation 5 Other	n 3 🗆 Remo	20b. PLACE cemetary, cre					y 5	-9-9	20c. LO	cation –	City or To	wn, Stata New J	erse	
	21. SIONATURE OF FUNERA	L SERVICE LIC	ENSEE				_				 ineral				
	Lisa	D. 0	Vellia	ms							Va. 22		IIIC 5		
	23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart Isiliure. L	List only one caus	coused the dee on each line	A	RR	the mo		ng, suc		diec or reapi	ratory an	reat,		nsta Between nd Death
CERTIFICATION	Sequentially list condit if sny, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS	diate NG ry	HIP DUE TO (C	PL FOR AS A CONSECUTOR AS A CONSECUTOR REPORTED TO THE PROPERTY OF THE PROPERT	OUENCE OF		RE IN.	FE	CT	10/	V				
MEDICAL	PART II. Other significe	nt conditions	s contributing to d	eeth but not r	resulting in	the un	derlying	ceuse g	lven in	Pert I.	24s. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY AVAILABLE PRIO COMPLETION OF OF DEATH?	R TO CAUSE
N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										1 YES 2	HU			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 V NO 26. PLACE OF OEATH (Check only one) OTHER: 1 VINDER OF OEATH (Check only one) OTHER: 1 VINDER OF OEATH (Check only one) OTHER: 1 VINDER OF OEATH (Check only one)														
ВУ РНУ		Pending investigation	28a. DATE OF II (Month, Day	JURY	28b. TIME INJU	OF	28c. INJI WO	JRY AT			SCRIBE HOW IP	NJURY OC	CURED		
60	3 Suicide 8	Could not be detarmined	28a. PLACE OF building, et	INJURY — At ho c. (Specify)	ome, ferm, st	reet, facto	ory, office			28f. LOC City	ATION (Street a or Town, State)	nd Number	or Rural A	loute Number,	

MERLY W

31. DATE FILED (Month,
MAY 2 2

ation, in my opinion, death occured at the time, data and placa, and due to the cause(a) end manner as stated.

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

BALTIMORE, MARYLAND 21215-0020

			1 - FOR STATE REGISTRAR	STATE OF 1	MARYLAI	ND / DEPAR CERTIF					MENTAL HYGIEN	_		
			1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH D	AY	YEAR	TIME OF DEATH
			WILLIAM 4. SOCIAL SECURITY NUMBER	LUEL 5. SEX				RMA			MAY 1			5:45 Pm
	pi		212-26-1995	1 🕅 M 2 🗌 F	6. AGE (III	yrs. last birthday) YRS.	MONTHS 1	DAYS	HOURS 9	HRS. MIN.	May 1, 19		II. BIRTHPL Country)	Ga.
	should	~	Sa. FACILITY NAME (If not institution, give at	treet end number)			9b. CITY, T	TOWN O	R LOCATION	OF D	EATH	9c. COUNT	Y OF DEAT	ГН
	1, 2, 3	2	1503 E.COLDSPR	ING LAN	IE		BAL'	TIN	10RE	CI	TY	<u> </u>	N/A	
	Pages	DIRECTOR	10a. STATE 10b. COUNTY	N/A			y, TOWN OR ltimor		ION					d. INSIDE CITY LIMITS? [X] YES 2 NO
	sit permit.	FUNERAL	100. STREET AND NUMBER 1503 E. Coldsp	oring Lar	ne				ZIP CODE				_	T COUNTRY?
cian.	bunal-transit	SNO	11. MARITAL STATUS	12. WAS DECEDEN		J.S. ARMED	13. WA			HSPAI	NIC ORIGIN? (Specify Ye			American Indien,
21215-0020 al or attending physician.	計	ВУ	1 Never Married 2 XXMerried 3 Widowed 4 Divorced	FORCES?			II y	yes, spe	elfy Cuban, I	Mexica Specif	in, Puerto Rican, atc.)		Black, W Specify:	Black
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AND 21	of be	COMPLET	Elementary/Secondary (0-12) 12TH	College (1-4 or 5 N/A	+)	Truck I	se retired.)		e or working		Kane	Trans	fer	
YLA by the	be detached at once.	E CO	17. FATHER'S NAME (First, Middle, Last) Johnnie Norman						18. мотнея От ga		ME (First, Middle, Meiden ONES	Sumame)		
MAR	5 should notified	0 8	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (S	Street er	nd Number or	Rural	Route Number, City or Tow	n, State, Zip C	Code)	
	be no	F	Pauline Norman			1503	E. Co	olds	spring	j L	ane Balti	more,	Md 2	1218
E E	director, pa er must b		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State		RRT'SON				T	51995 O	CATION — CI WINGS	ty or Town	State LLS, MD
P 20	ral di		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					D ADDRESS					
BALTIMO after death. Page 6	n by the funeral di removal. odical examiner		Hala 1	Mar	ch		M 4 3	arch 300	n F/F Waba	l W	est Avenue Ba	ltimo	re, M	d 21218
S			23. PART I. Enter the diseases, or c ehock, or heart fellure. I	List only one ceu	use on anc	ha death. Do i h line.	not anter th	ha mod	de of dying	, suc	h aa cardiac or reap	ratory arre	st,	Approximata Interval Between
within 24 h	ompletely filled al, cremation, o event, the m		immediate cause (Final disease or condition resulting in death)			erotic		dic	vasc	ul	ar Disea	se		Onset and Death
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requires	x. of Healt	Σ									_/ INSP	ECTIO	II I	YES 2 NO
<u>*</u>	23 dept	AN	DID TOBACCO USE CONTR	RIBUTE TO CA		PLACE OF DEAT			UNCER	ILAT	1 [2]			
AN: The	State	SICI	EXAMINER?	HOSPITAL:			OTHER:							
	d, or	PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIM	E OF 26	Bc. INJE	JRY AT	ence	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCU	RED	
Z E	death with	BY	1 Netural 5 Pending 2 Accident Investigation	(Month, D	ray, roer)	INJ	URY M	1 Y	ES 2 N	0				
ATTENDING	after de	B	3 Suicide 8 Could not be determined	28e, PLACE C building,	F INJURY — etc. (Specify)	At home, farm, s	Rreet, factory	y, office			281. LOCATION (Street of City or Town, State)	and Number of	Rural Route	Number,
5 8	3 P =	COMPLET									to the cause(s) end mer			
THE HOSPITAL	within 72 I		2 MEDICAL EXAMINER		1		···, ar my opin	riiori, de						
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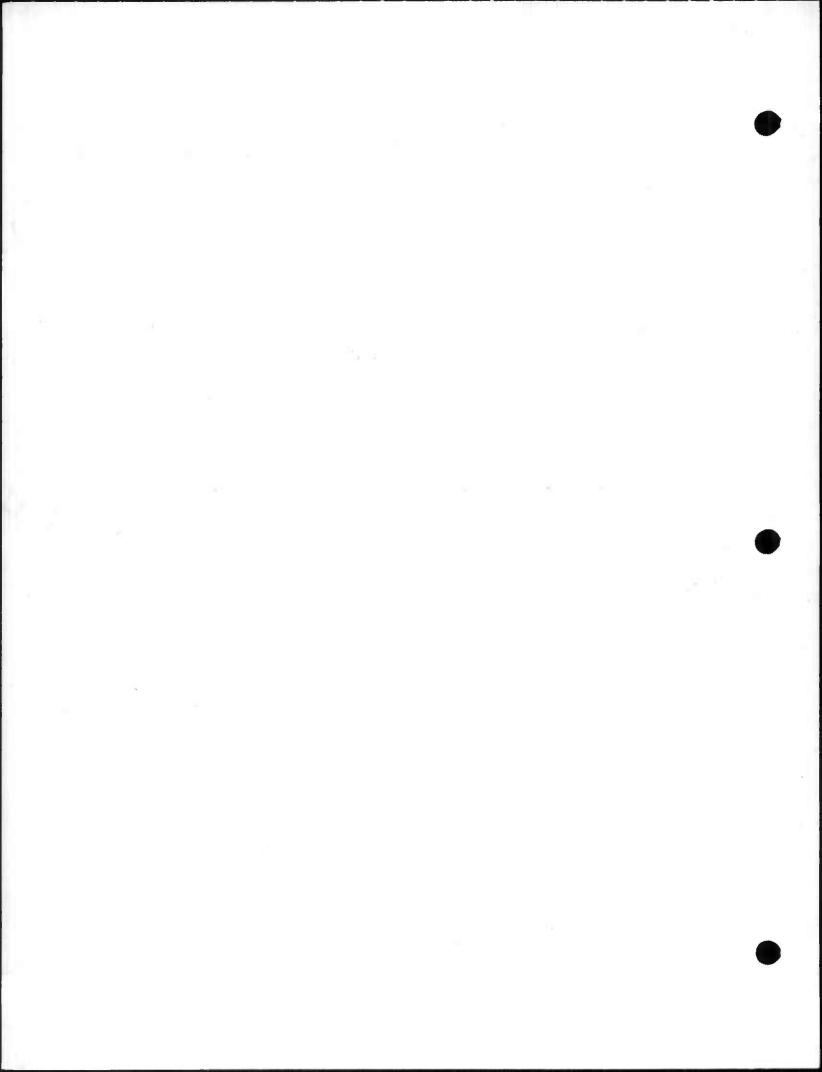
DEATH/(ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

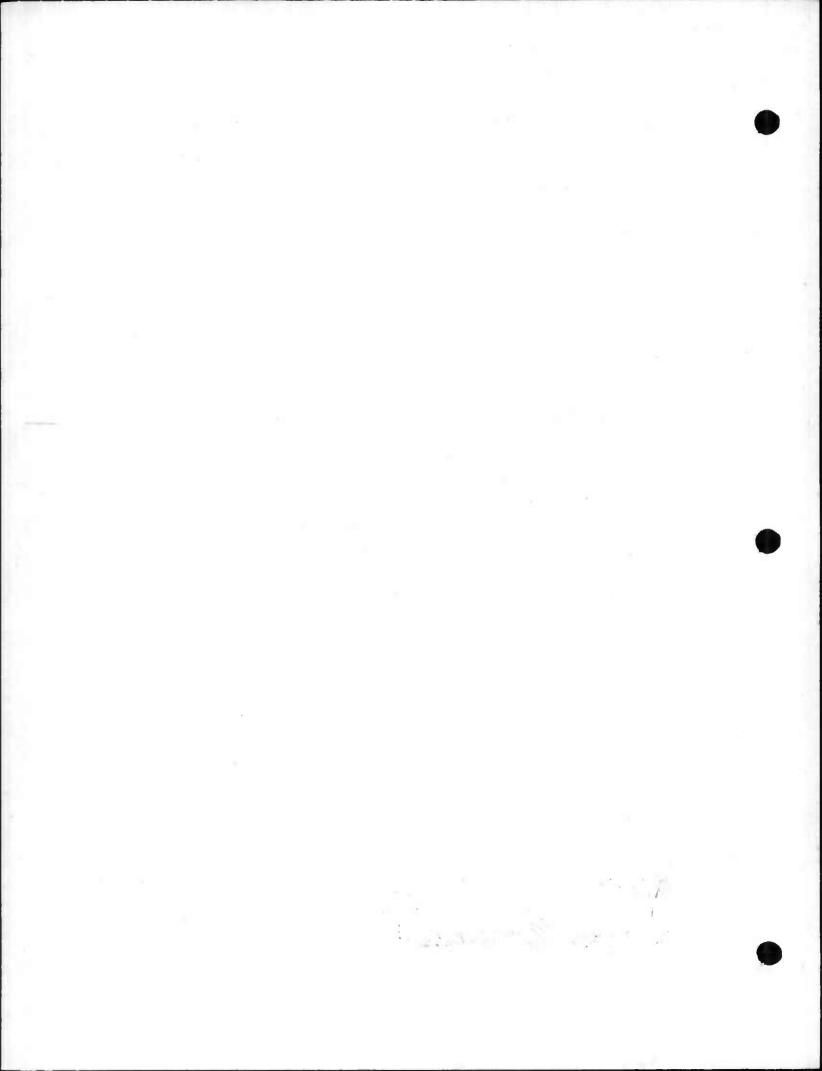
It	em # 10b,10d Film # G 72	3 5-22-95 N	I.A. Per	fun	eral Home				95		5657	
	1 - FOR STATE REGISTRAR	STATE OF MA			RTMENT OF H			ENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATN			3. TIME OF DEATN	
	WILLIAM	CLYDE	O	WEN	S			May 18, 199	5	YEAR	8:37 p	M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	. AGE (In yrs. last I	birthday)	IF UNDER 1 YEAR	IF UNDER 24	1000	T DATE OF BUTTH		8. BIRTNI	PLACE (State or Foreign	_
	226 18 5237	1 🔀 M 2 🗆 F	79	YRS.	MONTHS DAYS	HOURS	MIN.	Mar. 8,191	16	Country	jinia	
	9a. FACILITY NAME (If not institution, give street	et and number)			9b. CITY, TOWN C	O LOCATION				NTY OF DE		_
œ	John Hopkins Bayvie		1 Conto				OF DEA	"	90. 000		MIN	
DIRECTOR	RESIDENCE OF DECEDENT	sw Medica	ii cence	ALL.	Baltimo	re				N/A		
Ö	10a. STATE 10b. COUNTY	0.1.1		10c. CIT	Y, TOWN OR LOCAT	TION				1	10d. INSIDE CITY	_
=	Maryland -N	Baltimore (County	B	altimore					- 1	LIMITS?	
7	10e. STREET AND NUMBER					. ZIP CODE			10a CITI	TEN OF W	HAT COUNTRY?	_
FUNERAL	7941 Wynbrook Road				1	CONTRACTOR	4	1	iog. Citi			
Z		12. WAS DECEDENT E	THE MILL A. A. D. A.			2122				U.S.		_
F	1 Never Married 2 Married	FORCES? 1 V	YES 2 NO	ED)	13. WAS DEC	ENDENT OF ecity Cuben,	Mexican,	ORIGIN? (Specify Yes of Puerto Rican, etc.)	or No —	14. RACE Black	- American Indian, White, etc.	
BY	3 Widowed 4 Divorced	World War	OR DATES		1 🗌 YES	2 10 0	Specify:			Specifi	White	
	15. DECEDENT'S EDUCA			EDENT'S	USUAL OCCUPATIO	NI .		101 1011 00 000			MILLOC	_
	(Specify only highest grade co	ompleted)	(Give	e kind of a	work done during mose retired.)	st of working		16b. KIND OF BUSI	NESS/IND	DUSTRY		
7		College (1-4 or 5+)			,			Doord of	c na			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		GI	OUIK	dsman			Board of		ıcatı	.on	_
								E (First, Middle, Meiden S				
BE	Andrew Owens					Grac		Burched	,			
6	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Street e	nd Number or	Rural Roo	ute Number, City or Town,	State, Zip	Code)		
	Ronnie A. Owens		36	1 E	ndsleigh	Ave.	Mid	dle River,	Mai	rylan	d 21220	
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove	el from State			OF DISPOSITION (Na	me ot		DATE 20c. LOC	ATION —	City or Tow	vn, State	
	4 Donation 5 D Other (Specify)		Holly	Hil.	l Men. G	arden	s 5/	22/95 Balt	imon	re Co	ounty, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE			22. NAME AN	D ADDRESS	OF FACIL	LITY				_
- 3)	• 11 12	0	1					neral Home				
	23. PART L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											
	23. PART L Eater the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allock, or heart failure. List only one cause on each line.											0
- 14	IMMEDIATE CAUSE (Fine)	01	/		/		1	0 0			Onset and Death	
	disease or condition resulting in death) a. Choling on foreign books.											
- 1		DUE TO (OF	R AS A CONSEQU	ENCE OF	F): 0	20	.,40,000	yndron ed c ps				
Z	Sequentially list conditions.	Molo	CV	A	V5. 7	117	5	undrom	e.			
E I	if any, leading to immediate	DUE TO (OF	R AS A CONSEOU	ENCE OF	F):	4		7	121	3		
2	CAUSE (Disease or Injury				AS	s dis	eus	ed c ps	Deron	ueli	<	
ERTIFICATION	that initiated events	DUE TO (OF	R AS A CONSEQU	ENCE OF	F):	440		1				
E	resulting in death) LAST		Donald	1 St	Whigh	OCI	116	y phone	١.			
0	DART II Other cignificant and distant			1 573	1/1// 1// 1//	-1-11	AIL					
PHYSICIAN: MEDICAL	PART ii. Other significent conditions of	contributing to de	ath but not res	annig	the underlying	ceuse giv	en in Pa	ert i. 24a. WAS AN A PERFORM			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ĕ			7.0. 1	9.				_ 1 D YES 2	NO		COMPLETION OF CAUSE OF DEATH?	
闄											1 TES 2 NO	
ż	DID TOBACCO USE CONTRIE	BUTE TO CAUS	SE OF DEATH	H YE	S NO	UNCE	RTAIN	D				
NA N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEAT	H (Check only one)							-
Sic	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	OSPITAL:	R/Outpatient 3	DOA	OTHER: 4 Nursing Home	5 Reald	tence 8	Other (Specify)				
È	27. MANNER OF DEATN	280. DATE OF INJ		26b. TIMI	E OF 28c. INJU	JRY AT		ed. DESCRIBE HOW IN.	JURY OCC	CURED		Н
	1 Netural 5 Pending	(Month, Day,	Year)	INJ	M 1 Y		90	Chili -	<i>4</i> 7)1	A		
BY	3 Suicide & Could and be	28e. PLACE OF IN	NJURY - At home	Jarm.	street, fectory, office	7	2	BI. LOCATION (Street an	d Number	Name of the	. 1	-
	4 Homicide 6 Could not be determined	building, etc.	. (Specky)	_	,,		- 1	City or Town, State)	Ame	or representation	ote remoet,	
	29a. CERTIFIER					_		100				4
P P	(Check only							the cause(e) end menn				Н
COMPLETED	2/ MEDICAL EXAMINER:	On the beals of exam	ination end/or inv	estigatio	n, in my opinion, de	esth occured	at the tim	ne, date and place, end	due to th	e cause(e)	end mariner ee stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIEM	1/-	MT	>		29c LICENS	SE NUMBE	ER /	29d. DATE	SIGNED (Month, Pay, Year)	+
	141	111			Į.	5K3	364	3748	•	5/11	9/25	
유	30. NAME AND ADDRESS OF PERSON WHO	Contractive Course					- [-	1 .	/	ل

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CAUSE OF DEATH (ITEM 27) (Type, Print)

Old N. Point

	_	1 - FOR STATE REGISTRAR	STATE OF M		D / DEPAI CERTIF				MENTA	NEG. NO				
		1. DECEDENT'S NAME (First, Middle, Last) WILLIE	GRAY		PUL	LEY			2. DAT MON MA			YEAR	TIME OF DEATN	_
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yn	s. last birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	OF BIRTH	1		ACE (State or Foreign	V2
Should		246-90-5854 9a. FACILITY NAME (If not institution, give a	1 X 2 F	43	YRS.			R LOCATION OF D		21, 1	951	N. C	AROLINA	
2, 3 sh	СТОВ	1721 HARFORD A						MORE	EATH		9c. COUNT	n/a	N	
Pages 1,	ш	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Υ		10c, CI	Y, TOWN OR	LOCATI	ON				10	Dd. INSIDE CITY	
permit. Pa	DIR.	MARYLAND	n/a			BAL	TIMO	ORE				1	LIMITS?	
	ERAL	100. STREET AND NUMBER 1721 HARFORD A	VENUE				10f.	21213			10g. CITIZI		STATES	
020 physician. burial-transit	FUNE	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1					NDENT OF HISPA				4. RACE -	- American Indian, Vhite, etc.	_
	BY	Never Married 2 Merried 3 Widowed 4 Divorced	ARMY	AR OR OATES				2 XXNO Specific		Hican, etc.)			BLACK	
or attending	ETED	15. DECEDENT'S EDU (Specify only highest grade		18a	Give kind of	work done du	CUPATION oring most	N t of working	16	b. KIND OF BU		STRY		_
ND 21 hospital or ached for u	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		LABOR					BW	II AIF	RPORT		
S de la	COMPL	17. FATHER'S NAME (First, Middle, Last)					T	18. MOTHER'S NA	AME (First,	Middle, Malden	Surneme)			
ed by	BE	UNKNOWN 190. INFORMANT'S NAME (Type/Print)							LLIE					
be retained ge 5 should e notified	5	BETTY MC CORM	ICK	27.00	1721		Street en RFOR	D AVEN					21213 AND 2121	14
		20s. METHOD OF DISPOSITION 1 X Juriel 2 Cremetion 3 Rem	oval from State	cemetery	CE AND DATE	OF DISPOSIT	ION (Nan		DA	TE 20c. LO	CATION — CI	ty or Town	, State	
- 0 0		4 Donetion 6 Other (Specify) 21. BIONATURE OF FUNERAL SERVICE LIC	CENSEE /)	J SH.	LOH B			ADDRESB OF FA	5-2	4 L AR	COLA,	L. CA	ROLINA	
	- 13 	Bernard D	Johnson	ריו		MI	4. C	. MARCH	FH.	-1101	E. NO)RTH	AVENUE	
ted within 24 hours after completely filled in by the fial, cremation, or removal sevent, the medical		23. PART I. Enter the diseases, or abock, pr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Ather	oscler	lina.	Cardi		scular	6			nt,	Approximata Interval Betwo Onset and De	
certificate be executing physician and tygiene prior to burn other traumatik	RTIFICATION	Sequentially list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	С		NSEQUENCE O									
E Me o	L CE	PART II. Other algorificant condition	a contributing to d	death but n	ot reaulting	In the unde	eriving	cause given in	Part i.	24s. WAS AN	ALITOPSY	24h W	ERE AUTOPSY FINDIN	ice
and the shape of t										PERFOR	RMED?	CC	MILABLE PRIOR TO IMPLETION OF CAUSE DEATH?	
e law requires has been sign Dept. of Healt		DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF D	EATH Y	S N	0 🗆	UNCERTAIL	NA			'	YES 2 K NO	
ate the H	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		LACE OF DEA	OTHER:								
the the	PHYS	27. MANNER OF DEATN	1 Inpatient 2 I	NJURY	26b. T(M	E OF 2	Sc. INJU	5 Reeldence	_	or (Specify) SCRIBE NOW I	NJURY OCCU	RED		
DING PHYS After this of death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day					K? S 2 NO						
TTENDI TTENDI TTOR: A after da	ED	3 Suicide 6 Could not be determined	28e. PLACE OF building, a	INJURY — A rc. (Specify)	t home, farm,	street, factory	y, offics		281. LOI City	CATION (Street of Town, Stete)	and Number or	Rural Rout	e Number,	
Z 70 =	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYINO PNYSI 2 X MEDICAL EXAMINE											id manner ee stated	J.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	w l	296. SIONATURE AND TITLE OF CERTIFIER	1 10	7				29c. LICENSE NUI	MBER		29d. DATE S	SIGNED (M	onth, Day, Year)	_
D D S M	TO B	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CALLS	JE M		Drine1			OCM	E	► MA	Y 19	9,1995	
+1		THE RESTRICT OF PERSON WIT	- JOHN SELED CAUSE				tre	et. Ba	1+i	more	Mary	lan	d 21201	
`		MAY 2 2 1995	32. PEGISTRAR	'S SIGNATUR	iE			, 20				Luii	~ ~ ~ ~ ~ VI	

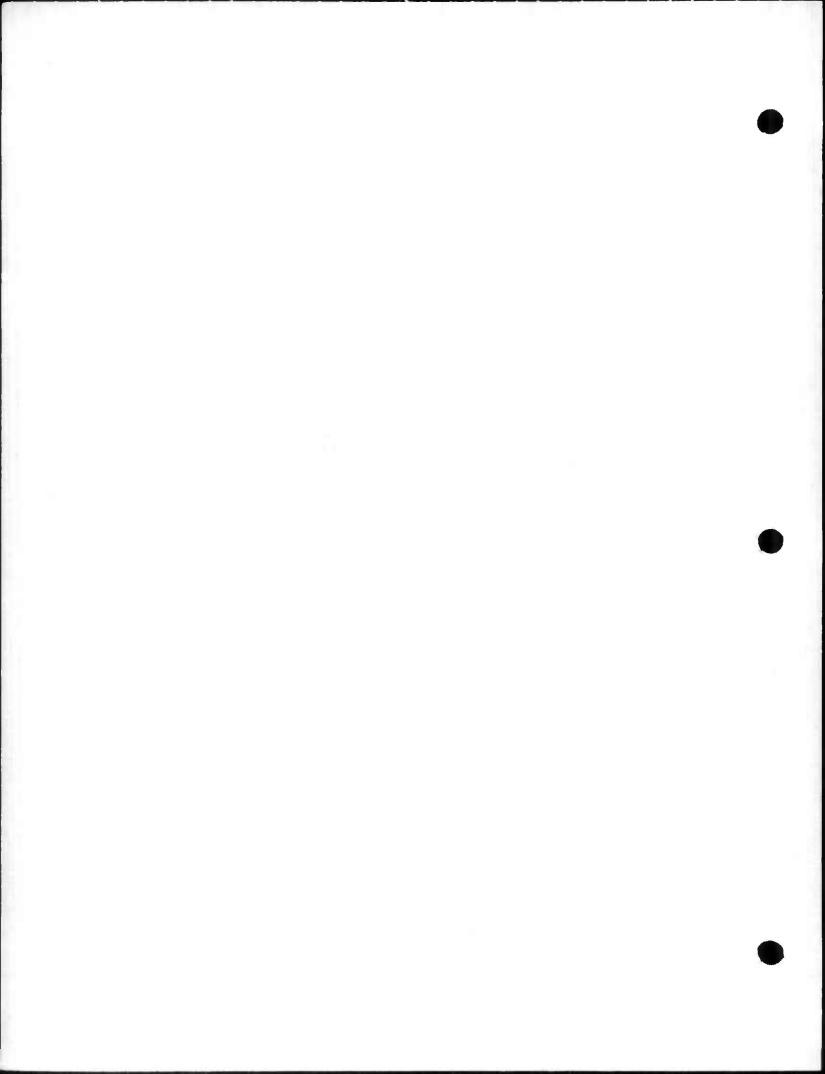


BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MA			MENT OF I		MENTAL	HYGIEN			
1. DECEDENT'S NAME		7						OF DEATH			3. TIME OF DEATH
Willia			farr				MONTH 05	2		S YEAR	11:00 PM
4. SOCIAL SECURITY N 220-09-0	432	X M 2 ☐ F	AGE (In yrs. lest	YRS.	F UNDER 1 YEAR ONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE ((Month, Oct	Dey, Year)	1917	Country	yland
9a. FACILITY NAME (N / Bay View RESIDENCE OF CO. STATE Maryland	Medical			9		imore	EATH		9c. COUNT	Y OF DE	ATH
10a. STATE	10b. COUNTY				TOWN OR LOCA					T	10d. INSIDE CITY
		timore		Mid	dle R						1 YES 2XX10
315 Dark		oad				21220				EN OF WI	A .
10e. STREET AND NUM 315 Dark 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4	Married	2. WAS DECEDENT E FORCES? 15 IF YES, OIVE WAR	OR DATES	IED O	if yes, ap	ENDENT OF HISPA ecify Cuban, Mexico 25 100 Specifi	an, Puerto R	(Specify Yes		14. RACE Block,	- American Indian, White, etc.
	DECEDENT'S EDUCAT	TION	WW II	EDENT'S US	UAL OCCUPATION	ON	16b.	KIND OF BU	SINESS/INDU		WIIICC
Elementary/Seconda	ry (0-12)	College (1-4 or 5+)	We. I	Do NOT use i	,	st of working					
12				Ink	Maker		_		r Con	pan	У
						Berth			,		
10. INFORMANTIC NAS			196.	MAILING AI	DORESS /Street &	nd Number or Rural				Cords)	
Esme Pfa	cr					Rd. Ba					220
20a. METHOD OF DISPO 1 Surial 2 Court 4 Doration 5 0	ation 3 🗆 Ramova	al from State			disposition (No	y 5/24	/199	5 Ba	cation — ci	ity or Tow	n, State County
21. SIGNATURE OF FUN	ERAL SERVICE LICEN	SEE	\ \		Bruze	D ADDRESS OF FA Zinski Old Eas	Fun				
23. PART I Eriter th	diseasea, or con	npileations that c	aysed the dea	th. Do not	enter the mo	de of dying, suc	ch as cardi	ac or reap	ratory arre	at,	Approximate
IMMEDIATE CAUSE	r namit failure. Lia	it only one cause	on each line.								Interval Between Onset and Death
disease or condition resulting in death)	→ a	Intra DUE TO (OF	Cereby	JENCE OF:	hemo	orrhag	e				8 days
		Nonket DUE TO (OF						rate			3 days
Sequentially list con if any, leading to im	mediate	OUE TO (OF	AS A CONSEOL	JENCE OF):							9
cause. Enter UNDER CAUSE (Disease or that initiated events		DUE TO (OF	AS A CONSEQU	IENCE OFI							-
reaulting in death) L	AST d.										
PART II. Other algni	licant conditions of	contributing to de	ath but not re-	sulting in	the underlying	cause given in	Part I.	24s. WAS AN	AUTOPSY	24b. \	VERE AUTOPSY FINDINGS
								PERFOR	4		MAILABLE PRIOR TO COMPLETION OF CAUSE
	<u> </u>										F DEATH?
DID TOBACCO		BUTE TO CAUS				UNCERTAI	N 🗆				
25. WAS CASE REFERRE EXAMINER?		IQSPITAL:	26. PLACE		(Check only one)						
1 TYES 2 TO	1	Ø\npstient 2 □ EI		DOA 4	☐ Nursing Hom	s 5 🗆 Residence	8 🗆 Other	(Specify)			
~	Pending Investigation	28a. DATE OF IN. (Month, Day,	Year)	26b. TIME C	WO 1 1	RK? 'ES 2 NO	28d. DESC	RIBE HOW II	NJURY OCCU	RED	
3 Suicide 8	Could not be determined	28a. PLACE OF IP building, atc.	(JURY — At hom . (Specify)	e, farm, stre	et, factory, offic			TION (Street a Town, State)	and Number of	r Rurel Ro	ute Number,
	ERTIFYING PHYSICIA										and manner as stated.
29b. SIONATURE AND TI	Sil		mo			29c. LICENSE NUI 9504	6		> 5	- 21	Month, Day, Year) - 95
JENNIF	ER YOU			27) (Type, Pr	10SP 600	N WOLF	E 50	9 PATH	101064	BALT	MDE MODELY
31.MAY 2 2 7	395° Juli	3 REGISTRAR'S	GNETUPE								
1,											DHMH-18 Rev 5/6



ained by the hospital or attending physician.

Nould be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cértificate be executed within hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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With	Thplete	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	vent,	ı
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	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND A	DEPAR ERTIF					MENTA	L HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last)	0 1	1					-		OF DEATH	40	VEAD	3. TIME OF DEATN	
DIRECTOR	Ervin L.	Paste	rnak						05 19 95 8:32				PM	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Ia		IF UNDE	R 1 YEAR	IF UNDER		7. DATE	OF BIRTH		B. BIRTN Countr	PLACE (State or Foreign	gn
	212443009	1 XM 2 □ F	52	YRS.	MONTHS	DAYS	HOURS	MIN.	03	126/	43		ÍRGINIA	
	9a. FACILITY NAME (If not institution, give st				R LOCATIO		ATN			INTY OF D				
	Sinai Hospital Baltimore Baltimore										ore City			
EC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											10d, INSIDE CITY		
DIR	MARYLAND		CATONSVILLE								LIMITS?	0		
	10e. STREET AND NUMBER					101	. ZIP CODE	E			10g. CIT	IZEN OF V	WHAT COUNTRY?	
ER.	1305 MIDDLEFORD F	ROAD					212	228		U.S.A.				
FUNERAL	t1. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A				IC ORIGIN? (Specify Yes or No.— 14. RACI			E — American Indian, k, Whita, etc.	_			
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 AR OR DATES	It yes, specify Cuban, Maxican, Pual 1 ☐ YES 2√ NO Specify:				n, Puarto /:	Specify:			the		
			-									WHITE		
TE	t5. DECEDENT'S EDUC (Specify only highest grade	completed)	(0	ECEDENT'S Sive kind of DO NOT up	work done	during mo	ON st of workin	g	161	6b. KIND OF BUSINESS/INDUSTRY				
COMPLETED	Elementary/Secondary (0-12) H/S GRAD	College (1-4 or 5)	AB.			ΔN			NATIO	NAT.	неатл	TH LAB	
MO	17. FATHER'S NAME (First, Middle, Lest)				БОП	11011		VER'S NA	MF /First	NATIONAL HEALTH LAB.				
U U	STANLEY PASTERNAM	(SACHS				
00	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	nd Number	or Rural I	Route Num	lumber, City or Town, State, Zip Code)				
5	SHARON PASTERNAK 1305 MIDDLEFORD ROAD - CATONSVILLE, MD 21228													
- 9	20s. METHOD OF DISPOSITION 1 N Buriel 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemeters of other piece) 20c. LOCATION — City or Town, State 5/24 BALTIMORE													
1	21. BIOMATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL H							OME IN	C .					
	* Klowid K	W A	anni									RE, N	ID 21229	
	23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line.													
	IMMEDIATE CAUSE (Final													
	disease or condition resulting in death) a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):							se						th
	DUE TO (OR AS A CONSEQUENCE OF):													
N	Sequentielly list conditions,	b												
ERTIFICATION	of any, leading to immediate cause. Enter UNDERLYING													
E C	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
E	resulting in deeth) LAST													
빙	G													
¥	PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS ANALIABLE PRIOR TO													
8	Pulmonary Disease 1 DTES 2 - NO										COMPLETION OF CAU OF DEATH?	SE		
M	1 YES 2 NO										•			
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO													
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:													
PHYSICIAN: MEDICAL	1 YES 2 NO 1 Propetlant 2 ER/Outpetlant 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify)													
	1 Netural 5 Pending	Netural 5 Pandling (Month, Day, Year) INJURY WORK?						28d. DE	DESCRIBE NOW INJURY OCCURED					
B	2 Accident Investigation Investigation Investigation Accident Investigation Investigat								CATION (Street and Number or Rural Route Number,					
COMPLETED	Suicide Could not be building, etc. (Specify) City or Town, State) City or Town, State) City or Town, State) City or Town, State)													
PLE	29a. CERTIFIER (Check only) 1 CERTIFYING PNYSICIAN: To the liest of my knowledge, dasth occurred at the time, data and place, and dua to the cause(s) and manner as stated.													
No.	one) MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED/(Month, Day Year)													
O BE	alle Minum MD 044841 >5/20/95							20195	-					
2	30 NAME AND ADDRESS OF PERSON WAS	O COMPLETED CAUS	SE OF DEATH /ITE	M 27 (Tens	Onint1	_								

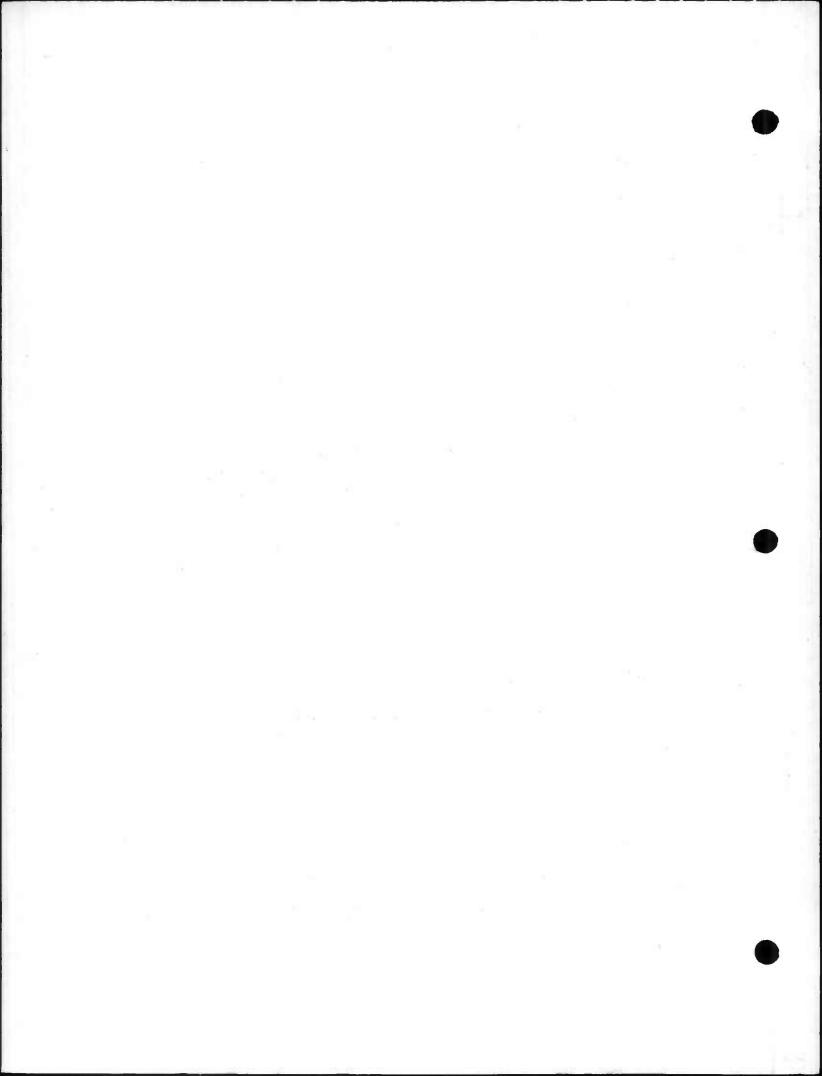
Wolfe St

PENSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) MD, 600 N.
32. REGISTRAR'S SIGNATURE

1995

DHMH-16 Rev 1/89

21205



OHMH-18 Rev 1/89

REG. NO.

1 - STATE REGISTRAR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR LILLIAN PAKULSK Lillian Gladys Pakulski 4 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 13-16-5133 1 M 2 F Maryland Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NURSING BAYVIEW DIRECTOR Baltimore City FACILIT N/A 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Parkville 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 3833 Glenview Terrace 21236 United States after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cubsri, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 🖔 Widowed 4 🗌 Divorced White funeral director, page 5 should be detached for use as the ED 18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Homemaker Own Home Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Friedel notified at Johanna Olivear 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Joan Ringger 1224 Delbert Avenue Dundalk, Maryland 21222 the medical examiner must be 20a. METHOD OF DISPOSITION
1 D Burlal 2 Cremation 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Oak Lawn Cemetery May 19,1995 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. Dear T aldred 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. **Approximate** ehock, or heart fellura. Liet only one cause on each lina. interval Between Metastatic ovarida carcuna IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition recuiting in death) event, DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. If any, leading to immediate cause. Enter UNDERLYING nal Forla CAUSE (Diseese or Injury other OUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in deeth) LAST 10 PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL any COMPLETION OF CAUSE 1 YES 2 NO DF DEATH? 23 shows 1 YES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO V UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item 2 **EXAMINER?** HOSPITAL: 1 YES 2 NO OR ATTENDING PHYSICIAN: 1 Ampatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v В Investigation Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office 28 is r 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL (= 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE FUNERA
be filed within Z
IMPORTANT: II 290 SIGNATURE AND TITLE OF PERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER THE FIELD BE 161 D28461 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5505 Hopkins Bayvier Ba Richard Bennett 31. DATE FILEO (Month, Day, Year) 32 REGISTRAR'S SIGNATURE ali black

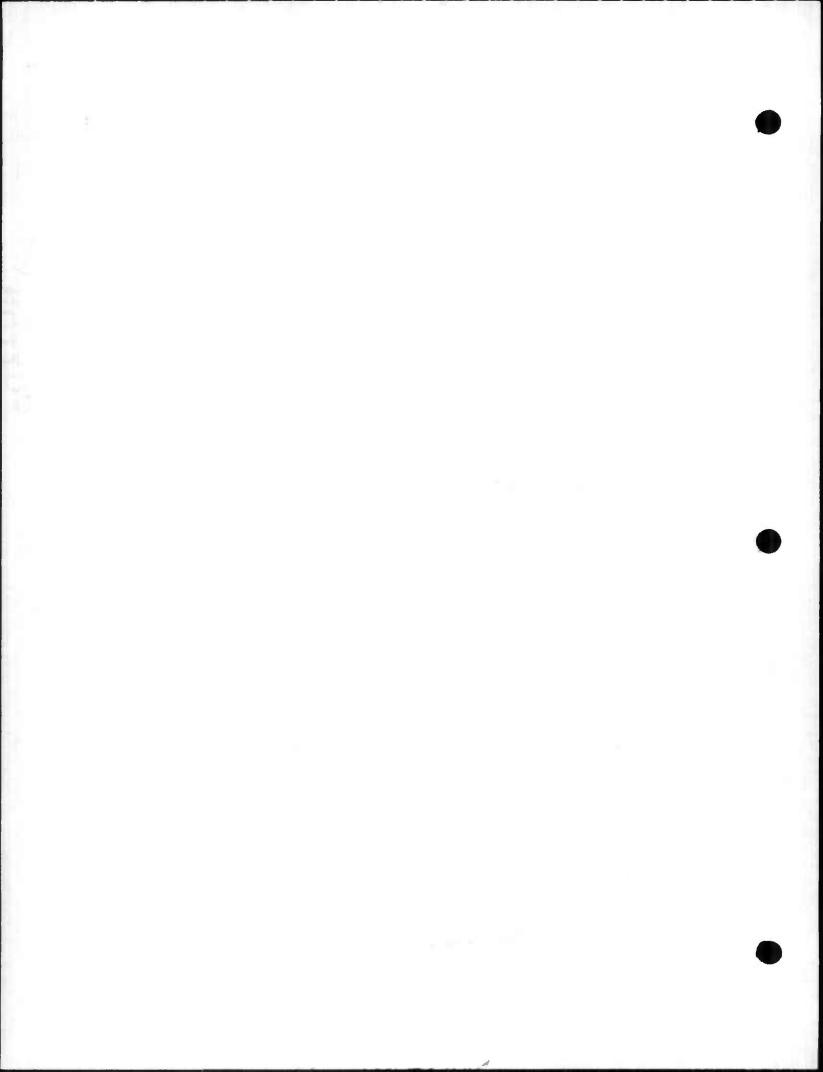
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTRENDING PHYSICIAN: The law requires that the death certificate be executed within the mode of the retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Detot, of Health and Mental Houlene prior to burial, cremation, or named.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	IMPORTANT: If item 28 is market

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.									
	1. DECEDENT'S NAME (First, Middle, Last) KENNETH	Р.	QUINLIN			2. DATE OF DEATH MONTH 18,		3. TIME OF DEATH 4;00 AM M		
	4. SOCIAL SECURITY NUMBER 226 28 1276	MXM 2 □ F	(In yrs. lest birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH June 2, 1	BIRTHPLACE (State or Foreign Country) 1rginia			
TOR	9a. FACILITY NAME (If not institution, give street and number) 2224 Hawthorne Road Middle River BESIDENCE OF DECEMENT									
DIRECTOR	10a. STATE 10b. COUNTY	imore	town or Locat			10d. INSIDE CITY LIMITS? 1 YES 24 NO				
FUNERAL	10a. STREET AND NUMBER 2224 Hawthorne	101	21 2 2 0	U.S.A.						
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DEC	RACE American Indian, Black, White, atc. Specify: White					
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	USUAL OCCUPATION of done during monor retired.) Driver	TRY							
NO	17. FATNER'S NAME (First, Middle, Last)	DIIvel		ME (First, Middle, Maiden	ight (.0.				
	George Quin	nlin				Lee Sta	,			
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Tow	vn, State, Zip Coo	de)		
유	Phyllis Winebre	enner	2124 F	Redthor	n Road	Middle	River	A MARY1210		
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from State Can	PLACE AND DATE OF	F DISPOSITION (Na par placa)	me of	DATE 20c LO	CATION - CIN	or Town, State County, Md.		
	21. SIGNATURE OF FUNERAL SERVICE LIC	TI III	orra Hill	22, NAME AN	D ADDRESS OF FA	(150/32 BgT	.timore	County, Ma.		
ě	Jam 7/	reglyens	he	Bruzd	zinski F	uneral Hom		Maryland 21221		
	23. PART I. Enter the diseases, or o	complications that cause	the daeth, Do no	ot anter the mo	de of dying, suc	h as cerdiac or resp	iratory arrest.	, Approximata		
	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final							Interval Between Onset and Death		
l	disease or condition resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	immediat						
Z	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):							several are		
ATIC										
SE I	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	•				Several yns		
CERTIFICATION	resulting in death) LAST	d.						į		
5	CAPIT II Other classificant as all in a second seco									
PHYSICIAN: MEDICAL	PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 100 24b. WE AM CO									
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
ᅙ	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)									
Š Į	1 - YES 2 -MO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outp	etlant 3 🗆 DOA	OTHER: 1 Nursing Nome	5 Thealdence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Additional 5 Pending	(Month, Day, Year)						OW INJURY OCCURED		
D BY	2 Accident Investigation 3 Suicide 6 Could not be	reet, factory, office		281. LOCATION (Street a	Bf. LOCATION (Street and Number or Rural Route Number,					
COMPLETED	4 Nomicide determined City of Jown, State)									
린	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated.									
ဂ္ဂ	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
296. SIGNATURE AND TITLE OF CERTIFIER Salsa Signature And Title OF CERTIFIER Physician 29c. License Number								29d. DATE SIGNED (Month, Day, Year)		
요	30. NAME AND ADDRESS OF PERSON WHO	1/~	ATN (ITEM 27) (Type, F	Print)	24	410		7.9/3		
	SABA SIDE		405 8	stemme	ese Ru	vRd 1	Berlto	-moziazi		
	31 MAY 2 2 1995 Ju	32 REGISTRAR'S SIGN	ATURE							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and the feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

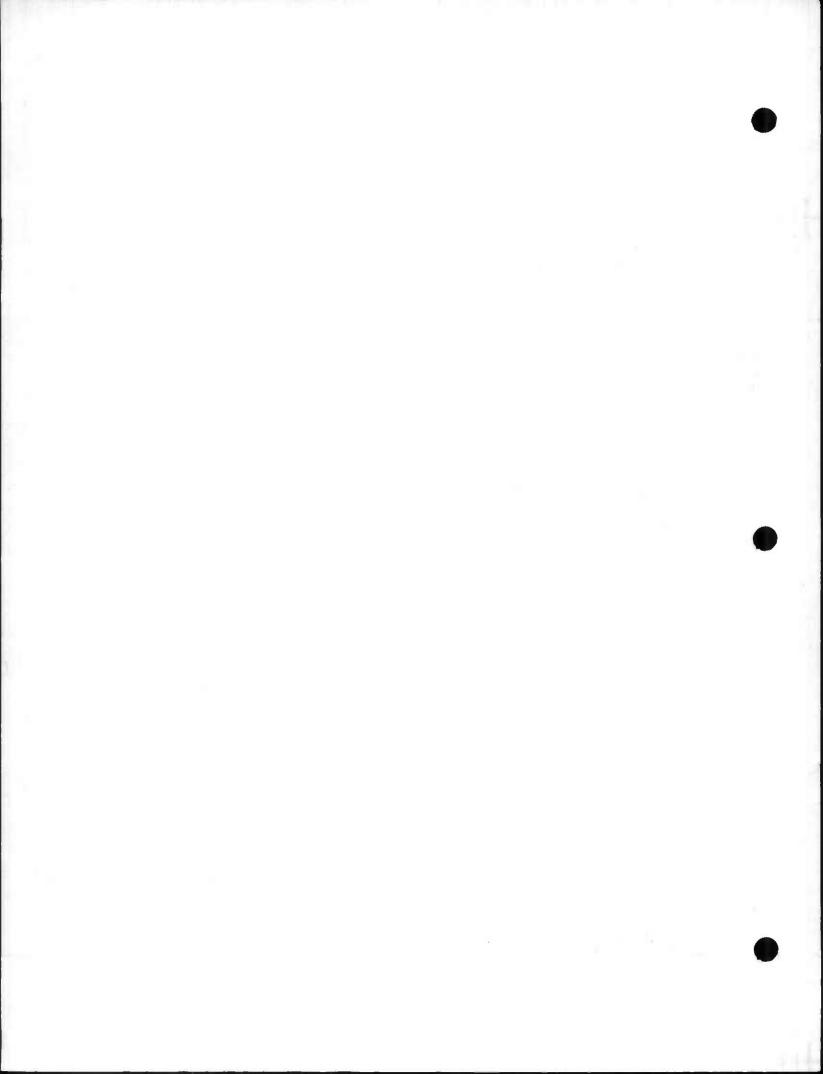
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

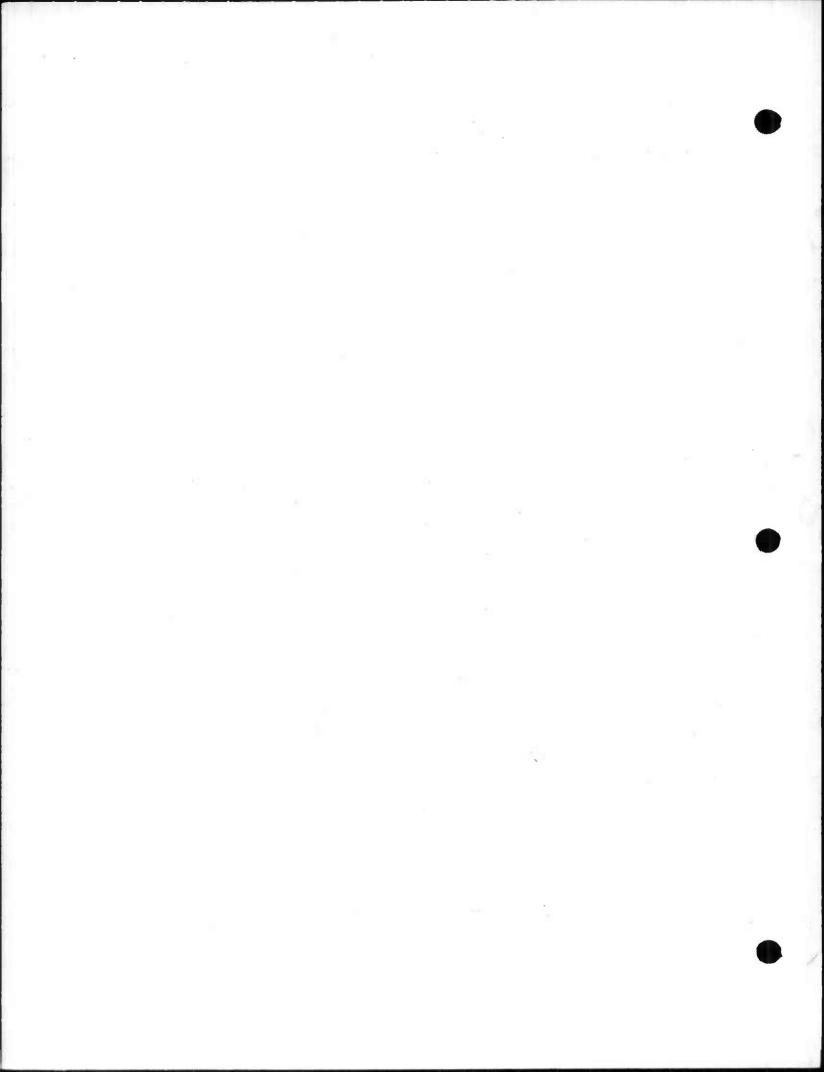
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH													
	FUE TVD PEDMANI PERMANI													
	4. SOCIAL SECURITY NUMBER		5. SEX 8. AGE (In yrs. lest		s. last birthday)	IF UND	ER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH				2:15 P. M
	214-18-7739		1 M 2 😿 F	72	YRS.	MONTHS	_	HOURS	MIN.	ept.	28. 1	1922	Count	yland
	9a. FACILITY NAME (If not instit			9b. CIT	TY. TOWN	OR LOCATI	ON OF DE		, 2		NTY OF C			
<u>د</u>	Franklin Sq	or	1		ville						e County			
DIRECTOR	RESIDENCE OF DECE	DENT	nobpicar	Cerree	- 1-		11033	ATTTE				Dare	TIIIO	e County
W.	toe. STATE	0b. COUNTY			10c. CI	Y, TOWN	OR LOCA	ATION						10d. INSIDE CITY LIMITS?
	Maryland	N,	/A			Bal	timo	re						1 X YES 2 NO
¥	10e. STREET AND NUMBER						10	of. ZIP COD	E			tog. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	2738 Kildai	re Dr	•					2	21234	4			USA	
ا يَ	11. MARITAL STATUS	547.	t2. WAS DECEDENT FORCES? 1	EVER IN U.S	S. ARMED	13	. WAS DE	CENDENT C	F HISPAN	NIC ORIGIN? (S	pecify Yee	or No-	14. RAC	E — American Indian, k, White, atc.
BY	1 Never Merried 2 \(\) Me 3 \(\) Widowed 4 \(\) Divorce		IF YES, GIVE W	AR OR DATES	A		1 YE	S 2 X NO	Specif	y:	iri, etc.)		Spec	
ED E		ENT'S EDUC	47/04	1 40		<u> </u>								WILLCE
	(Specify only hi	ighest grade	completed)		(Give kind of life. Do NOT u	work done	occupation during m	ION lost of working	g	16b. KII	ND OF BUS	INESS/IN	DUSTRY	
COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	Homer						wn Ho	omo.		
M	17. FATHER'S NAME (First, Middle	la Last)			nomer	llake	L	T 40 1107	15010	ME (First, Midd				
	James Welli	1100	Darrie							i Juli		,		
8	190. INFORMANT'S NAME (Type		_14115		19h. MAIL IN	ADDRE	SS (Street			Route Number,			o Codel	
9	Robert C. Ro									altimo			21234	1
	200. METHOD OF DISPOSITION			20h Pl /					7 100	DATE				
	1 Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sc		val trom State	cemetary	v cremetory or i	AND DATE OF DISPOSITION (Name of metory or other place) 1S OI Faith DATE 20c. LOCATION — City or Town, State Baltimore, MD								
	21. SIGNATURE OF FURERAL S		ENSEE	Joarc	ACTIO O.	22	NAME A	AND ADDRE	SS OF FA	CILITY				110
	► 1/ W.		OFA			A	LTEN	BURG	FUN	ERAL H				
	1/(1 /5/4	n/	allula	7						Rd., B				21214
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, above, or heart deliura. List only one cause on each line. Approximate interval Between Onset and Dasth Cardiovascular Collapse secondary to Septic Shock and Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
ᇤ	resulting in death) LAST		L.											
	DART II Other significant	PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
: MEDICAL	PANTII. Othar algoricant	not resulting	in that	indarlyir	ng cauaa (jivan in		PERFOR	MED?	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 \(\sum \) NO			
PHYSICIAN:	25. WAS CASE REFERRED TO A	MEDICAL					28. P	PLACE OF D	EATH (Ch	eck only one)				
S I	EXAMINER?		HOSPITAL:	ER/Outpatier	nt 3 🗆 DOA	OTHE	R:			6 Other (S				
主	27. MANNER OF DEATH		26e. DATE OF	INJURY	28b. TIN	IE OF	_	JURY AT	sidence	26d. DESCRI		JURY OC	CURED	
	1 Natural 5 Per	nding eatigation	(Month, Da	y, Year)	IN	JURY M		ORK? YES 2 [NO					
TED BY	2 Accident Investigation 3 Suicide 6 Con 4 Homicide det			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			Route Number,							
١٣	290. CERTIFIER 1 CERTIFY	ING PHYSIC	JAN: To the heat of	my knowledge	a death assure	and and Ab.	41-4-4-4				. (1)	37232 Y		
COMPLETED	(Check only one) 2 MEDICAL EXAMMEN: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner ee etated.													
BE	290: SIGNATURE AND TITLE OF CERTIFIER 290: LICENSE NUMBER 290: DATE SIGNED (Month, Day, Year) 167-20-95													
<u>و</u>	ph							L /	42	IR			0-	20-45
-	30. NAME AND ADDRESS OF P			E OF DEATH										
	Luis Ort				900	0 Fr	ank1	lin S	quar	e Dr.	Balt:	imor	e, M	D 21237
	31. PMAY 2"2"199	15 g	32. REGISTEAN	AT SIGNATUR	RE									



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	HOCOLL
	THE

		HEGISTHAR CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) Crace D. Stroud 2. DATE OF DEATH MONTH DAY GYEAR 1/1	OEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY 8. BIRTHPLACE (State	or Foreign
P		245-22-0402 1 M 2 DF 68 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) North C	ARding
2, 3 should	E E	Pa. FACILITY NAME (If not institution, give street and number) HOPKINS BAYVIEW M.C. BAINER N.A.	
-	5	RESIDENCE OF DECEDENT	
oit. Pages	DIRECTOR	MARYAND N.A. 10c. CITY, TOWN OR LOCATION 10d. INSIDE LIMITS? 1 MARYAND N.A. 10d. INSIDE	?
1. ansit permit.	ERAL	100. STREET AND NUMBER 302 South Bouldin Street 21224 U.S. A	177
the hospital or attending physician, detached for use as the burial-transit once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Merried 1 Never Married 4 Divorced 12. WAS DECEMENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO If YES 2 NO If YES, GIVE WAR OR OATES 13. WAS DECEMENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Black, White, etc. Specify: White, etc.	indian,
r aftend use as	8	15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY	
ospital or hed for u	APLET	(Specify only highest grade completed) Elementary/Secondary (0-12) Sth N.A. (Give kind of work done during most of working life. Do NOT use retired.) (For Menaker Own Home	2
the hospit detached once.	COMP	17. FATHER'S NAME (First, Middle, Last) / 18. MOTHER'S NAME (First, Middle, Maldlen Surneme)	
id be	BE (UNENOWN Every Unknown	
ay be retained by page 5 should be the notified at	5	19a. INFORMANT'S NAME (Type Print) LINDA Chery/ Woodward 2607 Larkhall Pall Balto Mal Z/Z	25
rector, pa		20g. METHOD OF DISPOSITION 1 Durisi 2 Cremation 3 Removal from State 4 Donation 5 Other Company Crematory or other place SALARWN CEM 5/22 BA/FO MICE	
death. Pag tuneral di I. examiner		21. SIGNATURE OF PUNESAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TOUGH AND THE PROPERTY OF THE PUNESAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	H.
he fur		[March Janeso 263 5. Crapling St Ball Md	21224
d in by the or removal	edica edica		ximate
		IMMEDIATE CAUSE (Fine)	and Death
ompletely filled, cremation, event, the		$\xrightarrow{\text{diseese or condition}} \Rightarrow \qquad \qquad \text{holding, fts} $	reek
P 2 4 9	_	Sequentially list conditions b. Pancrestic Cancer 11/2	1
be execution and crior to burit	ERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):	-71
leath certificate be attending physician mal Hygiene prior to y, or other traur	S	CAUSE (Disease or Injury Cardia Supraventrizule Tachy cardia 5)	hus
nding phy Hygiene p or other	E	thet initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST	
the attend Mental H Mury, or	9	d.	
at the dea by the att and Menta y Injury,	- 11	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED. AMALABLE PR	
uires that signed b Health ar	EDICAL	1 VES 2 NO COMPLETION DF GEATH?	
requires been sign of Hea shows	Σ	1 TYES 2	No
law has be Dept. 23 s	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF GEATH (Check only one)	1
N: The ficate h State	SICI	EXAMINER? HOSPITAL: OTHER:	
Sicia certif h the	PHY	27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 286. INJURY AT 286. DESCRIBE NOW INJURY OCCURRED	
After this cleath with	ВУ Р	1) Netural 5 Pending (Month, Dey, Year) INJURY WORK? Desident Investigation New Year) Netural 1 YES 2 NO Netural 1 YES 2 NO Netural 1 YES 2 NO Netural 1 YES 2 NO Netural 1 YES 2 NO Netural 2 No Netural 2 No Netural 3 No Ne	
OR ATTENDING PHYSICIAN: The law requires that the death certificate DIRECTOR: After this certificate bas been signed by the attending physichours after death with the State Dept of Health and Mental Hygiene prillem 28 is marked, or Item 23 shows any Injury, or other them 28 is marked, or Item 23 shows any Injury, or other them 28 is marked, or Item 23 shows any Injury, or other them 23 shows any Injury, or other them 23 shows any Injury, or other them 23 shows any Injury, or other them 23 shows any Injury.	ETED	3 Suicide 4 Nomicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N. A.	
로 가는 토	OMPL	29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. One) 1 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner.	as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 ? IMPORTANT: If I	BE C	296. SIGNATURE AND TITLE OF CENTIFIER 296. DATE SIGNED (Month, Day, V	bar)
/ 	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. Thomas Magnuson	7 J
7 1		31. DATE FILED (Month, Day, Year) 320 REGISTRAR'S SIGNATURE	
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SUNATURE	
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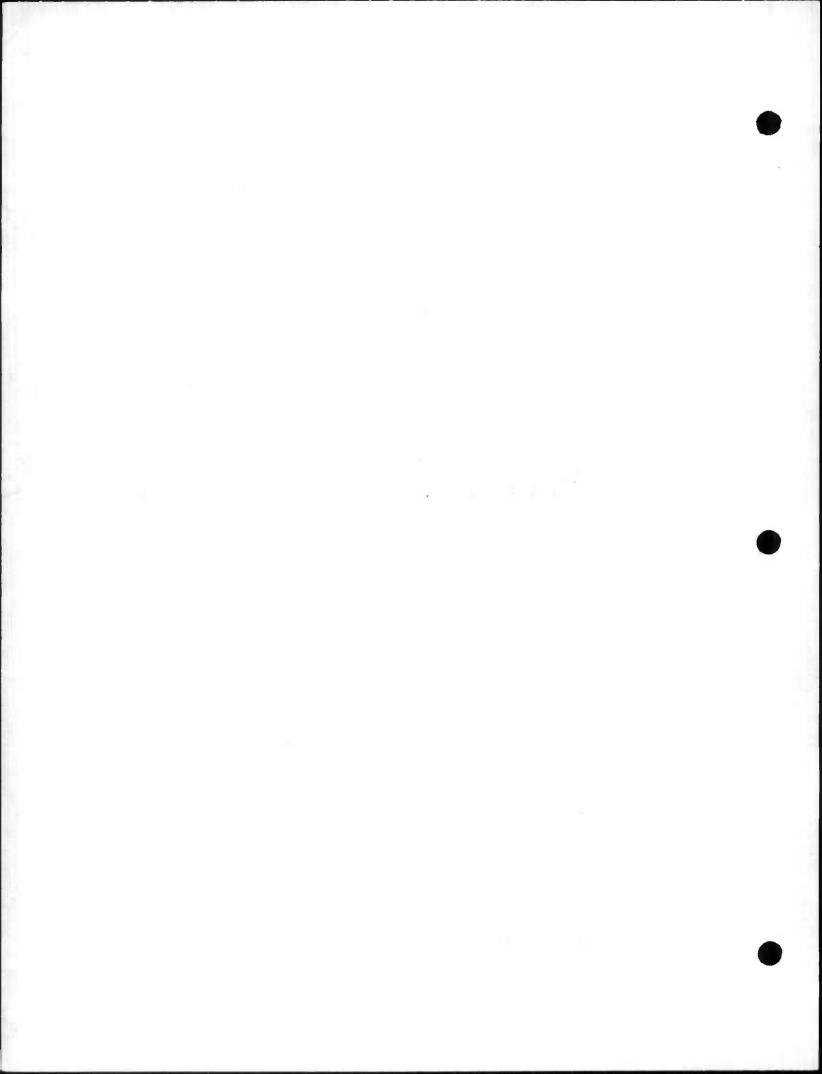
DHMH-16 Rev 1/89

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA	MENT OF H	EALTH AND	MENTAL HYGIE		
		1, DECEDENT'S NAME (First, Middle, La.	Lee	Sm	ith		2. DATE OF DEATH	00 19	3. TIME OF DEATH
pin		4. SOCIAL SECURITY NUMBER 220-24-6593-A 220-24-6593A	Xă м 2 □ F 67	YRS. MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-18-192	27	BIRTHPLACE (State or Foreign Country) West Virginia
1, 2, 3 should	TOR	94. FACILITY NAME (If not institution, given Fallston Gene		96	Falls	ton	DEATH	9c. COUNTY Hari	y of death ford
permit. Pages 1	DIRECTOR	Maryland Harf			esvill				10d. INSIDE CITY LIMITS? 1 YES 2 NO
75	FUNERAL		rmilk Road		101	21132			N OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? MX YES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 X NO Speci	NIC ORIGIN? (Specify an, Puerto Rican, atc.)	Yes or No — 14	Black, White, atc. Specify: White
2121 al or atte	PLETED	15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12)		16e. DECEDENT'S USI (Give kind of work life. Do NOT use re Truck D	done during mo tired.)	ON st of working	000000000000000000000000000000000000000	star Co.	
YLA by the be det	I III	17. FATHER'S NAME (First, Middle, Last) Charles W.	Smith	18. MOTHER'S			NAME (First, Middle, Melden Surneme)		
2 8 0	2	190. INFORMANT'S NAME (Type/Print) Irene T. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10					
e 6 ma ector, p		20e. METHOD OF DISPOSITION 1 Strict Burlet 2 Cremetion 3 Red 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	FO	PLACE AND DATE OF D tery, crematory or other rk Christ	ian Ch	urch Cem	n. 5-23-95	Fork,	•
BALTIN s after death. Pag by the funeral di emoval. dical examiner		→ Wallace	S. Brook	Be, In.	Ruck 1050	York Roa	uneral Ho	, Md. 2	21204
within 24 pletely fill cremation, rent, the		23. PART I. Enter the diseases, of shock, or heart feilur IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute Re	ch line.					interval Between Onset and Death
P.O. BOX 68: th certificate be execute ending physician and co il Hygiene prior to buria or other traumatic	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. Layge ce DUE TO (OR AS A C ANALM) Q DUE TO (OR AS A C	consequence of: due to	phon	19.			2 475.
AL RECORDS, he law requires that the dea he has been signed by the att e bept. of Health and Menta in 23 shows any Injury,	SAL		tery disease	,			1 TYES	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	PHYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF DEATH (C	check only one)	UNCERTAI	N 🗆		
2 9 5	HYSI	1 TYES 2 NO 27. MANNER OF BEATH	inputient 2 ER/Output	lent 3 DOA 4 DOA 4 D			8 Other (Specify) 28d. 0E\$CRIBE HOW	V INJURY OCCUE	RED.
ON OF OING PHYS After this of death with	ВУР	Natural 5 Pending Accident Investigation		INJURY		ES 2 NO			
DIVISION OR ATTENDING F DIRECTOR; After I hours after death Item 28 is man	ETED	3 Suicide 6 Could not b 4 Homicide determined	wording, mee (upout)	<i>-</i>			28t, LOCATION (Stree City or Town, Stel	fe)	Rurel Route Number,
절 보다 =	COMPLETED	(Check only	SICIAN: To the best of my knowled NER: On the bests of examination a			eath occured at the	time, data and place,		suse(s) and manner as stated.
TO THE HOSPI TO THE FUNER De filed within	TO BE	Potons	B-D-PA	REKHI	and the same of th	D 186		29d, DATE SI	1GNED (Month, Day, Year) 14 - 21 - 95
1ks		30. NAME AND ADDITIONS OF PERSON V	4 MD. 190	8 HAR		ROAD	PALLSTON	1, MD	21047.
In	3	31. DATE FILED (Month, Day, Year) MAY 22 1991	32. REGISTRAR'S SIGNAT	Revelati					

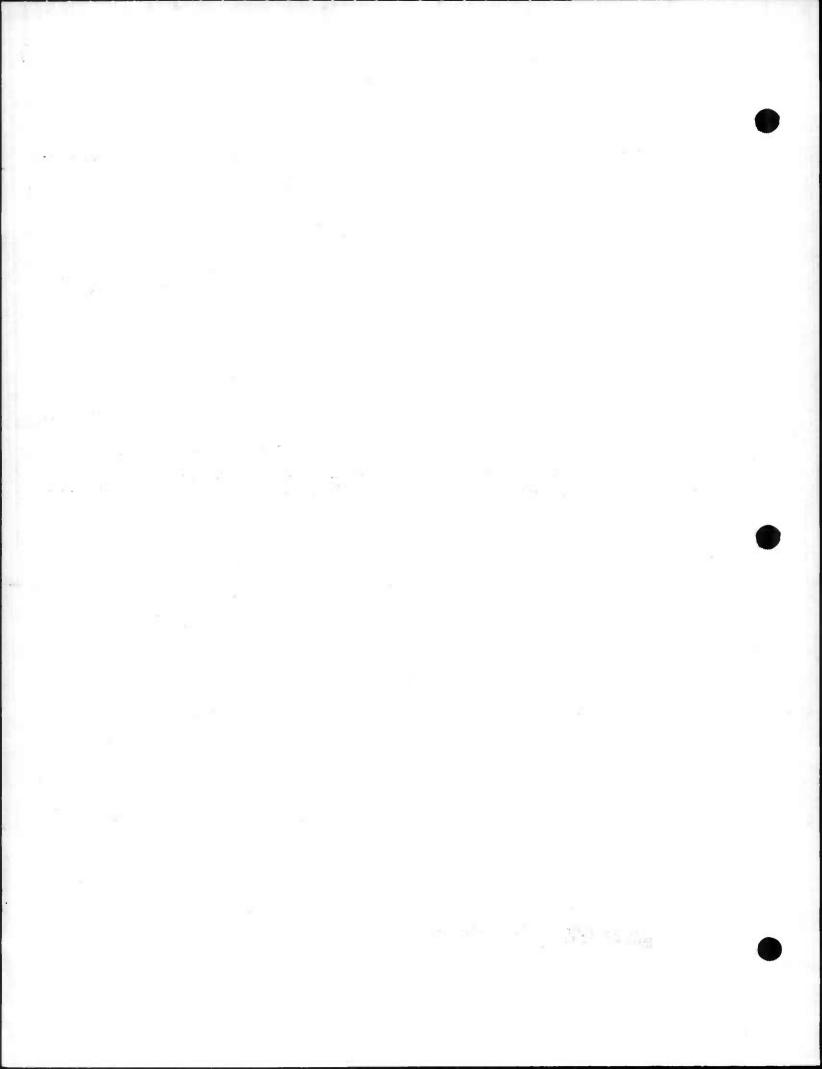
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BALTIMOR	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	THE FUNERAL DIRECTOR: After this certificate has been singed by the attending obsision and completely filled in by the funeral director of
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	death	atte
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		REGISTRAR	OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH ANI	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH			
		ANDREW R. S. 4. SOCIAL SECURITY NUMBER S. SEX	TEVENS 6. AGE (In yrs. last birthday)	-	05 20	0 95	1245 AM			
Should		215-01-2520 1 IX M 2	□ F 77 YRS. N	IF UNDER 1 YEAR IF UNDER 24 HRI NONTHS DAYS HOURS MIN	July27,	1917 Country	MD			
3 sho	Œ			9b. CITY, TOWN OR LOCATION OF		9c. COUNTY OF DE				
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Pages	IRE	10a. STATE 10b. COUNTY		TOWN OR LOCATION			10d. INSIDE CITY LIMITS?			
permit.	LDI	MD N/A	Bal	Ltimore City			1 TO YES 2 NO			
sit pe	BAL	_1433 Woodall Stree	· +	100 00 000	230	10g. CITIZEN OF W	S • A			
020 physician. bunial-transit	FUNE	11. MARITAL STATUS 12. WAS DE	ECEDENT EVER IN U.S. ARMED	13. WAS DECENDENT OF HIS		s or No.— 14. RACE	- American Indian			
215-0020 attending physic ise as the burial	BY F	3 Widowed 4 Discoved IF YES,	S? 1 X X ES 2 NO GIVE WAR OR DATES	If yes, specify Cuben, Mes 1 YES 2 5740 Spe		Black Specifi	White, atc.			
215-0 attending se as the	ED B	15. DECEDENT'S EDUCATION	KorenConflict, Vietr				White			
- 6 -	ETE	(Specify only highest grade completed)		rk done during most of working	16b. KIND OF BU	ISINESS/INDUSTRY				
O E E	PL	Elementary/Secondary (0-12) College (1-	Engine	er	U.S. A	YMK/				
the host detach	COMPL	17. FATHER'S NAME (First, Middle, Last)	1120,112		NAME (First, Middle, Maider					
# & & ~	BE (Andrew R. Stevens			May Georg					
retained 5 should	5	19e. INFORMANT'S NAME (Type/Print)		DORESS (Street end Number or Ru						
		Dorothy E. Stevens 20a. METHOD OF DISPOSITION		Noodall Stre						
B m Sing		\$ Surfel 2 ☐ Cremetion 3 ☐ Removal from St		er place)	į.	OCATION — City or Tov				
Page al direct		21. SIGNATURE OF FUNERAL SERVICE LICENSE	A St. Stanislau	22. NAME AND ADDRESS OF	FACILITY	altimore, M	aryland			
death fune		* Telest P 1 }	V. 1	Charles L. Ster			01000			
S after after by the nova		23. PART I. Enter the diseases, or complication	ns that caused the death. Do not	1501 E. Fort Ave	TIUE, BALTIMON	e, Maryland	21230			
- 6 .		IMMEDIATE CAUSE (Final	ne ceuser-sach line.				Interval Between Onset and Death			
= = = = = = = = = = = = = = = = =		disease or condition resulting in death)	Spiration Pne DUE TO (OR AS A CONSEQUENCE OF):	umonia						
S 5 5 5										
OA 68 be execut sician and or rior to buri	NO	Sequentially list conditions,	ELETURY'S DE	sease			-			
au cian	FICATION	cause. Enter UNDERLYING	to (or the translation of).							
ertifical ng phy giene I	TFIC	CAUSE (Disease or Injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
F the part is	ERTI	reaulting in death) LAST								
는 Marie	AL C	PART_II. Other aignificant conditions contribut	ing to death but not resulting in	the underlying cause given			WERE AUTOPSY FINDINGS			
	EDIC/	PARKINSON'S DISS	EASE		PERFO	*dua	MAILABLE PRIOR TO COMPLETION OF CAUSE			
requires the requires the signed of Health shows and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show	ME					V .	OF DEATH?			
TAL RECORD The law requires that te has been signed by the Dept. of Health and the Bank and the		DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEATH YES	□ NO □' UNCERTA	IN X					
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITA		(Check only one)						
SICIAN: The Certificate the State	PHYS		nt 2 ER/Outpatient 3 DOA 4 ATE OF INJURY 28b. TIME 0	□ Nursing Home 5 □ Residence OF 28c. INJURY AT						
F # # 5	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	fonth, Day, Year) INJUR	WORK? M 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURED				
OR ATTENOING DIRECTOR: After nours after death tem 28 is ma	ETED	3 Suicide 6 Could not be 4 Homicide determined	LACE OF INJURY — At home, larm, stre illding, etc. (Specify)	et, lactory, office	281. LOCATION (Street City or Town, State)	end Number or Rural Ro)	ute Number,			
로 보는 =	COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beautiful one) 2 MEDICAL EXAMINER: On the beautiful one of the beautif	best of my knowledge, death occurred ils of examination and/or investigation,	at the time, data end place, and d In my opinion, death occured at t	us to the cause(s) end ma	nner es stated.	and manner ee stated.			
THE HOSPI THE FUNEF filed within	BE C	295 SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE N	UMBER	29d. DATE SIGNED				
TO THE TO THE De filed	TO B	36. NAME AND ADDRESS OF PERSON WHO COMPLETE	D CAUSE OF DEATH (ITEM 27) (Type Pr	MRO6	56	15/20	195			
12		J. EANGARA MD	22 So. Greene	St. Baltin	sto ore, Md	21201				
		MAY O O MORE	GISTRAR'S SIGNATURE							
		n					DHMH.+6 Rev.+/89			



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	HEALTH AND N	MENTAL HYGIEI		
		1. DECEDENT'S NAME (First, Middle, Last) ALEXANDER 4. SOCIAL SECURITY NUMBER	W. Syn				May 1	9 199	3 1 1 0 0 1
should		716-16-3529 9a. FACILITY NAME (If not Institution, give st	1 M 2 □ F 79	YRS.	IF UNDER t YEAR		7. DATE OF BIRTH (Month, Day, Year) JUNE 27, 19	915	BIRTNPLACE (State or Foreign Country) PENNSYLVANIA
1, 2, 3 shc	стов	ST. AGNES HOSPITA	cackor ward.			TIMORE	ATH	9c. COUNTY	ALTIMORE CITY
permit. Pages	DIRE		ALTIMORE	10c. CiTY,	TOWN OR LOCAT	ONSVILLE			10d. INSIDE CITY LIMITS? 1 YES 2 NO
is.	NERAL	132 MAIDEN CHOICE				2122		U.S.	
B at	BY FUN	1 Never Married 2 Married 3 Wildowed 4 Divorced	FONCES? 1 (A) TES 2 NO If yes, specify Cuban, Mexic			ecify_Cuban, Mexican	can, Puarto Rican, etc.) Slack,		RACE — American Indian, Black, Whita, etc. Specify: WHITE
al or atte	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 1 2 TH GRADE	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use in	rk done during mo retired.)	ON est of working		USINESS/INDUST	RY
by the hospital be detached to at once.	E COMPI	17. FATNER'S NAME (First, Middle, Last) ALEX SYNOWSKI		ш. сс	DLUNEL	18. MOTHER'S NAM	ME (First, Middle, Meider (UNKNOWN)	ARMY	
retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) MR. DONALD VILLEI	LA				oute Number, City or To		MD. 21204
e 6 may rector, pa		20e: METHOD OF DISPOSITION 1 Burlat 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	MD	PLACE AND DATE OF etary, crematory or othe . VETS . CEM	DISPOSITION (Na or place) IETERY (FOREST GARRISON	5/23 OWI	NGS MIL	
death. tunera tunera examir		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	w	HUBBAI		L HOME IN VENUE-BAL		MD 21229
ithin 24 hours after of the filled in by the removal.		23. PART I. Enter the diseases, or c shock, or haert failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	list only one cause on ea	www.		de of dying, such	se cardiac or resp	iratory arrest,	Approximata Interval Between Onset and Death 2 W
in certificate be executed wanting physician and comp i hygiene prior to burial, cr	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF): CONSEQUENCE OF):					
uires that the signed by the Health and Mws any inju	MEDICAL (PART II. Other algorificant conditions The - here a Day.	contributing to death be	(1)	the underlying	g cause given in F	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
# # # E	PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH		UNCERTAIN			
PHYSICIA this certif with the irked, or	BY PHYS	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation	1 Inpetient 2 ER/Output 26a. DATE OF INJURY (Month, Day, Year)		OF 28c. INJ	e 5 Rasidenca (URY AT RK? /ES 2 NO	Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	D
OR ATTENDING DIRECTOR: After hours after death Item 28 is man	a	2 Accident Investigation 3 Suicide 6 Could not be datarmined	— At home, farm, atre	farm, atreet, factory, offica 28f. LOCATION (Street and Number or Rural Route Numb City or Town, Stete)			ural Route Number,		
로 걸었는	COMPLET		CIAN: To the best of my knowler: On the bests of examination						use(a) and manner as stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	- 3	MHO		29c. LICENSE NUMI	BER 1505	≥ MC	NED (Month, Day, Year) 24 19 1995
17,		30. NAME AND ADDRESS OF PERSON WHO	-RIAZ, J	R	- JT,	4500	14081),	V
4		MAY 22 1995	22. RESISTRATES SIGN	book		V	,		



BALTIMORE, MARYLAND 21215-0020

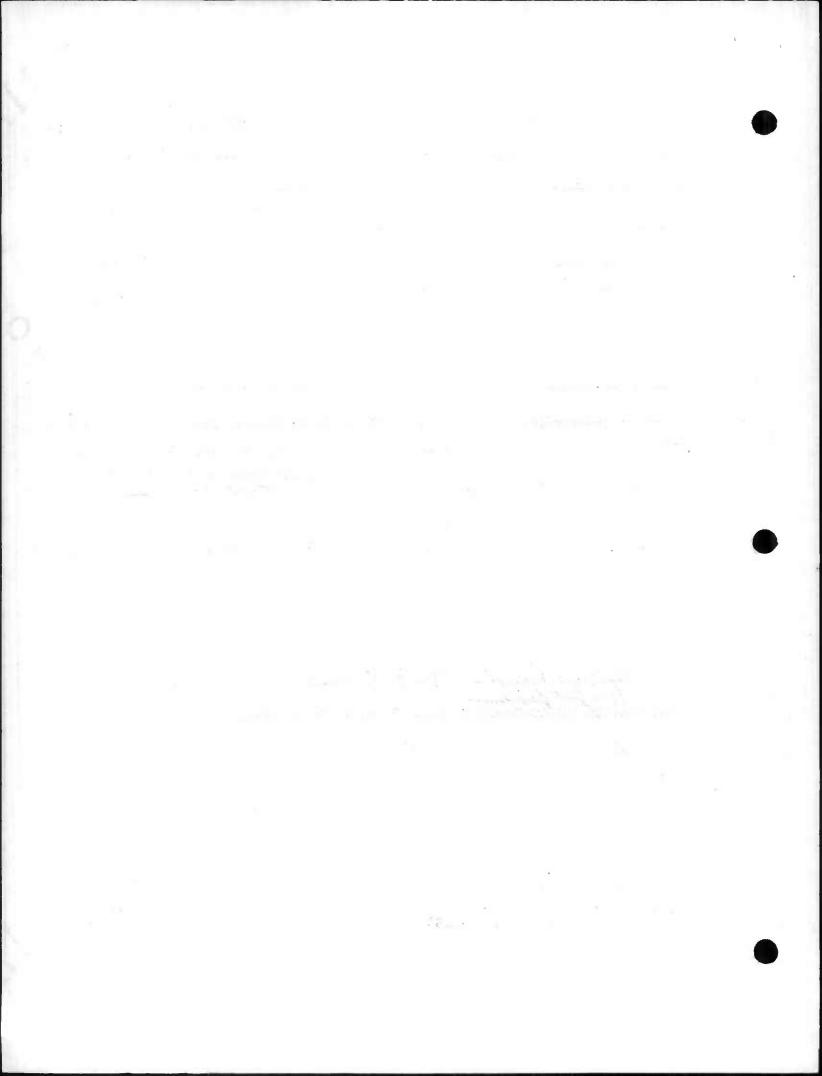
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) LILIE	SCHONBERGER				2. DATE OF DEATH	. 995 YEAR	3. TIME OF DEATH 8:00 P. M	
	4. SOCIAL SECURITY NUMBER 579-42-7852	1 MXXXXF		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH OCC . Day 1 (18)	1925 CZE	HPLACE (State or Foreign Choslovakia	
TOR	9a. FACILITY NAME (If not institution, give at 1031 Tracy Drive RESIDENCE OF DECEDENT	treet and number)			Spring	EATH	9c. COUNTY OF Montgon		
DIRECTOR	10a. STATE 10b. COUNTY	tgomery		er Spr				10d. INSIDE CITY VIMITS? THYES 2 NO	
FUNERAL	100. STREET AND NUMBER 1031 Tracy Drive			101	20904		U. S.	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married XX Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2)(NO	If yes, sp		IIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	a or No— 14. RACE — American Indian, Black, White, etc. WITTE		
COMPLETED	15. DECEDENT'S EOUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker					
BE CON	17. FATHER'S NAME (First, Middle, Last) Aaron Herskovcs				Ethel	ME (First, Middle, Malden Iskovitz			
10	19a. INFORMANT'S NAME (Type/Print) Isidor Schonbers		1031 Tr	acy Dr	ive, Sil	Route Number, City or Tow ver Spring	, Maryla		
	20b. PLACE AND DATE OF DISPOSITION OF DISPOSITION OF DISPOSITION OF DISPOSITION OF TOWN, State 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DATE OF LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DISPOSITION (Name of Committed of Disposition) 20b. PLACE AND DATE OF DATE O								
	Donald (Stota	-	232 CA	RROLL ST	REET, N.W.	, WASHIN	IGTON, D. C.	
CERTIFICATION	iMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. OUE TO (OR AS A OUE TO (OR AS A	consequence of:				iratory arrest,	Approximate interval Batween Onset and Death Syfars	
EDICAL	PART II. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions contributing to death but/not resulting in the underlying ceuse given in Part i. Part 1. Other algnificent conditions ceuse given in Part i. Part 1. Other algnificent conditions ceuse given in Part i. Part 1. Other algnificent conditions ceuse given in Part i. Part 1. Other algnific								
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 □ Inpatient 2 □ ER/Outp		THER:	ACE OF DEATH (Ch	8 Other (Specify)			
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO			28d. DESCRIBE HOW INJURY OCCURED		
8	3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLET		CIAN: To the best of my knowl R: On the beele of examination						(e) end menner as stated.	
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 178, 29d. DATE SIGNED (Month) May 15,								
	Dr. Jack P. Segal 5530 Wisconsin Avenue, # 505, Chevy Chase, Maryland								
	MAY 2 2 1995	W Williams	ione.						



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95 15669 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH WILLIAM ELMER SCARBOROUGH. MAY 16. 1995 6:50 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BUILDIN OCTOBER 4,1906 DAYE FACILISTON, MARYLAND 217-03-0291 1 M 2 F 88 HOURS YRS. 9a. FACILITY NAME (If not institution, give street and number) 96. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATN DIRECTOR IVY HALL GERIATRIC CENTER BALTIMORE COUNTY BALTIMORE RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE COUNTY 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1801 HANFORD ROAD 21237 USA 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cubsn, Mexican, Pusrto Rican, etc.)
1 YES 2 NO Specify: 14. RACE -- American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 💢 Widowed 4 🗌 Divorced Specific WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Ove kind of work done during most of working
life. Do NOT use retired.) 15. OFCEDENT'S EDUCATION 16h KINO OF BUSINESS/INQUISTRY (Specify only hi Elementary/Secondary (0-12) College (1-4 or 5 +) N/A MILKMAN KOONTZ DATRY 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First Middle Maiden Surname) JOHN OSCAR SCARBOROUGH EMILY B. BEAMEN BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES W. SCARBOROUGH 1801 HANFORD ROAD BALTIMORE, MARYLAND 21237 204 METHOD OF DISPOSITION

VA Burisl 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State PARKWOOD CEMETERY MAY 20, 1995 4 Donation 8 D Other (Specify) BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition resulting in death) iver adeno Metastatic Carcinoma 2 weeks DUE TO (OR AS A CONSEQUENCE OF): Cancer CERTIFICATION Sequentially list conditions OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 1 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Nomicide 29a. CERTIFIER (Check only one)

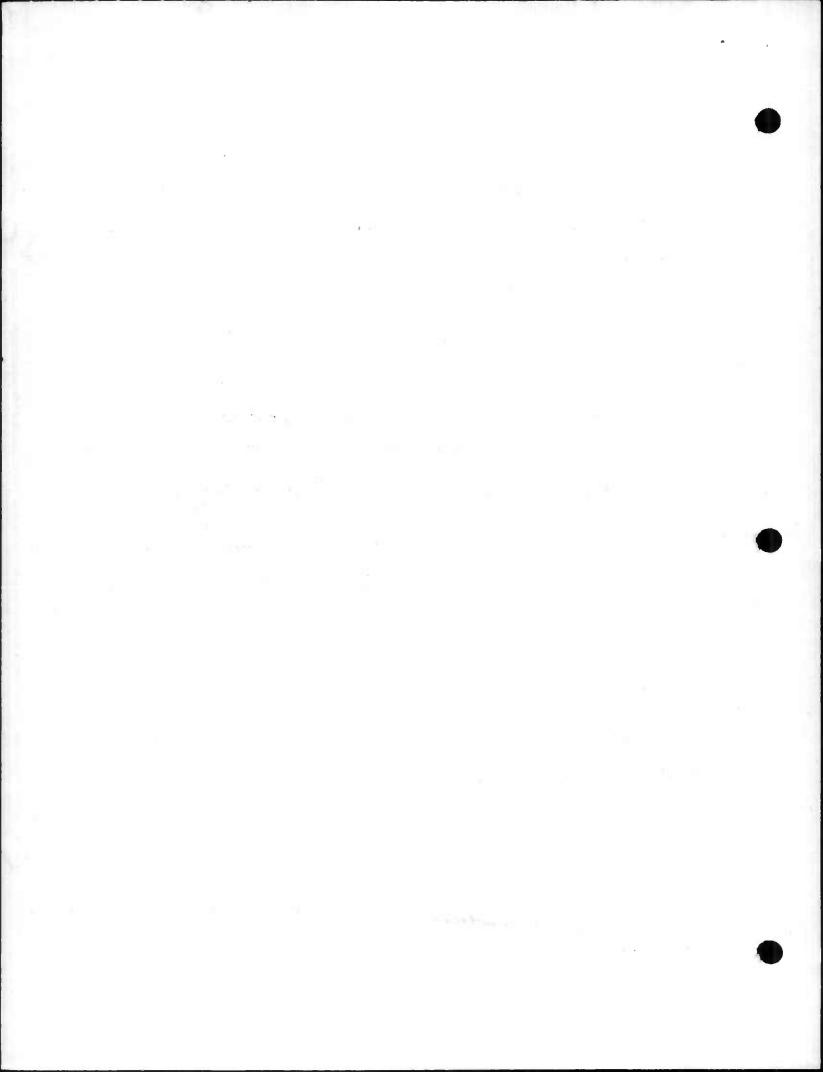
29a. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE Alobrash ► 5-17-95 1P MO MD 37612

Belair Rd

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

ALABRASH, MD, 9712 FILED MOON PORTURE

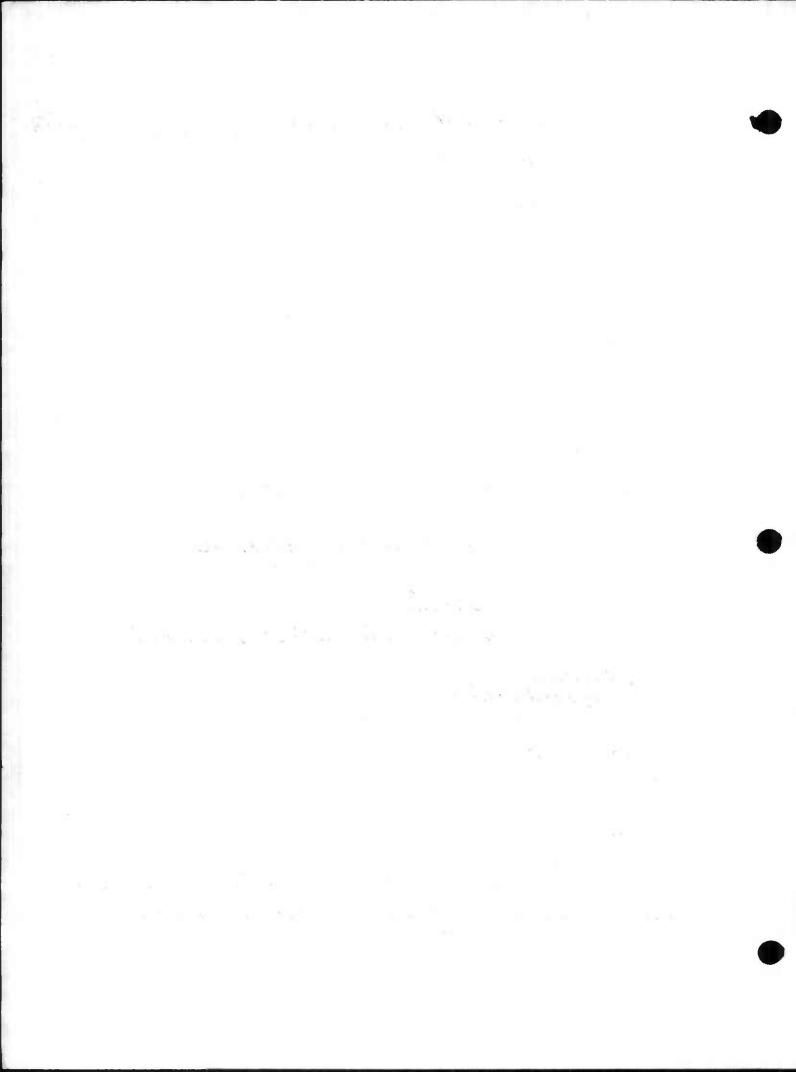
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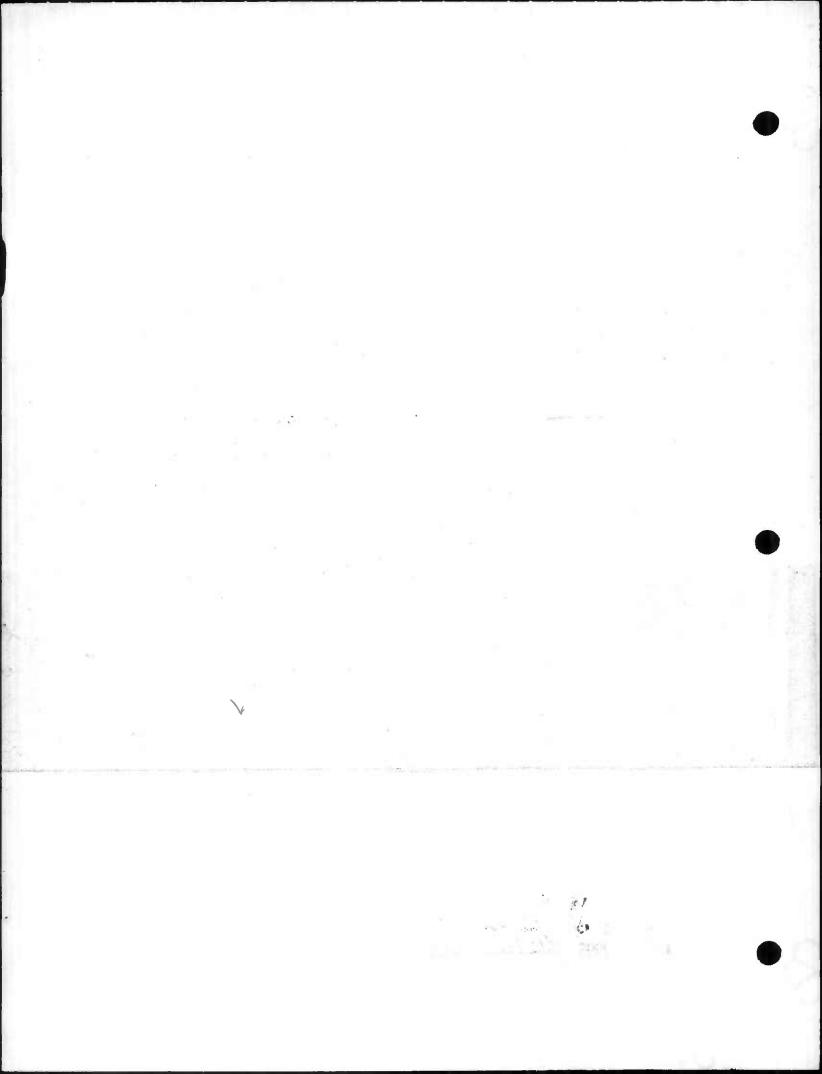
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	And the state of t
PITAL DR ATTE	NERAL DIRECTOR	W. 14 14 AA
108	N I	

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
		COMO		R	OSE	2. DATE OF PEATH MONTH VALUE	95 YEAR	3. TIME OF DEATH			
		M 2 □ F 8	In yrs. lest birthday) Res.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 05-06-0	Cour	THPLACE (State or Foreign stry) VA •			
DIRECTOR	9a. FACILITY NAME (If not institution, give street and NORTH WEST MEDIC RESIDENCE OF DECEDENT		ER	96. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY OF BALTO				
ñ	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	ATION			10d. INSIDE CITY			
	MD. BALTO.		PI	KESVIL	LE			1 YES 2 XNO			
AL	10e. STREET AND NUMBER				Of. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNER	7 SUDBROOK LAN	VE S DECEDENT EVER IN	U.S. ARMED	13. WAS DE	21208	IC OBIGIN2 (Specify Ven		USA o- 14. RACE — American Indian,			
B⊀	1 Never Married 2 Merried FO	RCES? 1 TYES YES, OIVE WAR OR DA	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: BLA							
TED	15. DECEDENT'S EDUCATION (Specify only highest grade complete		16a, DECEDENT'S (Give kind of a life, Do NOT us	work done during m		16b. KIND OF BUS	SINESS/INDUSTRY				
COMPLET	Elementary/Secondary (0-12) Colleg UNK	e (1-4 or 5+)	TRADE	SMAN UNK							
BE	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	18. MOTHER'S NAME (First, Middle, Maiden Surname)					
	EDWARD E. ROSE				EDITH HANDSLEY						
2	198. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	ARTHUR L. DRAGER 209_METHOD OF DISPOSITION	-			STREET	BALTIMO		21202			
	20a_METHOD OF DISPOSITION 1 A Burlei 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MT ZION CEMETERY 05-23-95 LANSDOWNE, MD.										
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		ZION		AND ADDRESS OF FAC		ISDOWNE	, MD.			
	· /////	1/1	_		BERT P.		/H PA				
	23. PART I. Enter the diseases, or complic	Who that caused	the death Do	638	N. GII	MOR STRE	ET 2	1217			
	ahock, or heart failure. Life only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): A TYPICAL										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	SET DUE TO (OR AS A	CONSEQUENCE OF CONSEQ	F):	TIVE LUN	VG DESE	785				
	resulting in death) LAST d. CHRONIC OBSTRUCTIVE (UNG DESERSE PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS										
DICAL		louting to dalith of	ut not resulting	In the underlyir	ng cause givan in i	Part I. 24a, WAS AN PERFOR		b. WERE AUTOPSY FINDING AMILABLE PRIOR TO			
ED	DEMENTA 1 YES 2 NNO COMPLETION OF CAU										
. ME	DID TORACCO LISE CONTRIBILITE TO CALISE OF DEATH VES VIOLE LINICEDTAIN I										
SICIAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 126. PLACE OF DEATH (Check only one)										
SIC	26. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 21. PLACE OF DEATH (Check only one) 22. PLACE OF DEATH (Check only one) 23. PLACE OF DEATH (Check only one)										
PHY		in. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN	JURY AT ORK?	28d. OEŞCRIBE HOW II	NJURY OCCURED				
ED BY	Could not be Coul	a. PLACE OF INJURY building, etc. (Speci	— At home, farm, s		YES 2 NO	26f, LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,			
OMPLET	29a. CERTIFIER CERTIFYING PHYSICIAN: TO CERTIF							(a) and menner as stated.			
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER	y tee	MI	>	29c. LICENSE NUM D 27/.	BER		D (Month, Day, Year)			
F	30. NAME AND ADDRESS OF PERSON WHO COMP	= /	NORTH		H09 P17	ALCENI					
	MAY 202 1995" Julia	THE THE NAME OF THE PARTY OF TH									



DHMH-16 Rev 1/89

			FOR STATE REGISTRAR	STATE OF MARYL		ND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
•			1. DECEDENT'S NAME (First, Middle, Leat)	une		*		2. DATE OF DEATH	5 1998	3. TIME OF DEATH 5:05 P N				
	pyr		4. SOCIAL SECURITY NUMBER 244-38-7971	1 □ M 2 K X 6		F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	OCT. 2, 1		BIRTHPLACE (State or Foreign Country) N. CAROLINA				
permit. Pages 1, 2, 3 sho		ECTOR	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE RESIDENCE OF DECEDENT 9b. CITY, TOWN OR LOCATION OF DEATH ANNE ANNE PER BURNIE ANNE											
	nit. Pages	DIR	MARYLAND 10b. COUNT	n/a	10c. CITY,	TOWN OR LOCAL BAL	TIMORE			10d. INSIDE CITY LIMITS? 1XXYES 2 \(\square\) NO				
		VERAL		HILL AVENU	10	21217		UNI	OF WHAT COUNTRY? PED STATES					
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	the the	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	N U.S. ARMED 2 2 144 ATES	If yea, ap	DENDENT OF HISPA Decify Cuben, Mexic 3 2 XXVO Speci	NIC ORIGIN? (Specify Yeen, Puerto Ricen, etc.) fy:	RACE — American Indian, Black, White, etc. Specify: BLACK						
	for use	LETED	16. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)		18b. KIND OF BU						
	COMPL	17. FATHER'S NAME (First, Middle, Last)	yrs.	LABOR	RER		STATE		PITAL					
			GENERAL LEE L	OCKHART			EDIE	AME (First, Middle, Melden WHITE	Surname)					
MAR		BE (190. INFORMANT'S NAME (Type/Print)	O CHITTIEL	19b. MAILINO A	ADDRESS (Street o		Route Number, City or Tow	n. State. Zip Co	Se)				
ED 40		2	BETTY WHITEB	White	1616			ROAD, BA						
S	ector, page		20s. METHOD OF DISPOSITION	oval from State	PLACE AND DATE OF	DISPOSITION (No	ame of		CATION — City					
IMORE Page 6 may	direct		4 Donation 8 Other (Specify)		RING ME				RANDAI	LISTOWN, MD				
BALT ter death.	by the funeral director, removal. dical examiner must		Bemand D	Somson		WM		RCH FH		E. NORTH AV				
The Hours	completely filled in by the fall, cremation, or remove: event, the medical		23. PART I. Enter the diseases, or shock, pr heart fallure/ IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Christian cause on a	the death. Do no not line.	ual	de of dying, sui	ch as cerdiac or reap	iratory arrest	Approximate interval Batween Onset and Death				
8 5 .	burial,	NO	Sequentially list conditions,	. Daseh	CONSEQUENCE OF:	ellis	cies			202				
BOX	physician a ne prior to ner traum	SAT	If any, leading to immediate cause. Enter UNDERLYING	. Clives	CONSEQUENCE ON:	en to	neal	Dorl	780	182				
O. Salific	r Hygie	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	consequence of):	opoli	fi C	7		Ywales				
S E	injer	님	PART II. Other significant condition	e contributing to death be	ut not resulting in	tha underlyin	g ceuse given in	Part I. 24a. WAS AN PERFOR	PMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
RECOR	pt. of Health and shows any	: MEDIC	DID TOBACCO USE CONTI	DIRLITE TO CALISE O	E DEATH VEC		UNCERTAI	-/		1 YES 2 NO				
A .	2 6 2	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	1	26. PLACE OF DEATH		UNCERIAI	NU		•				
- M	the State or New	rsic	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outp		OTHER:	ne 5 🗆 Rasidence	6 Other (Specify)						
OF FISH	Tree with		27. MANNER OF DEATH 1 Natural 8 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WO	URY AT ORK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUR	ED				
DIVISION OR ATTENDING P	after d	TED BY	2 Accident 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, str			281. LOCATION (Street City or Town, State)	and Number or F	Bural Route Number,				
HOSPITAL OR	ERAL DIRECTIONS IN 72 hours	COMPLET		CIAN: To the best of my knowl R: On the besis of examinetion						use(s) and menner as stated.				
THE HOS	THE FUNERAL De filed within 72 h IMPORTANT: If I	8	29b. SIGNATURE AND TITLE OF CERTIFIER		-		29c. LICENSE NU	MBER		GNED (Mogth, Day, Year)				
7	Z Z Z	2	30. NAME AND ADDRESS OF PERSON WHO					.W. 201 GLE		1 ()				
1			31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE				DOINI	12 21001				

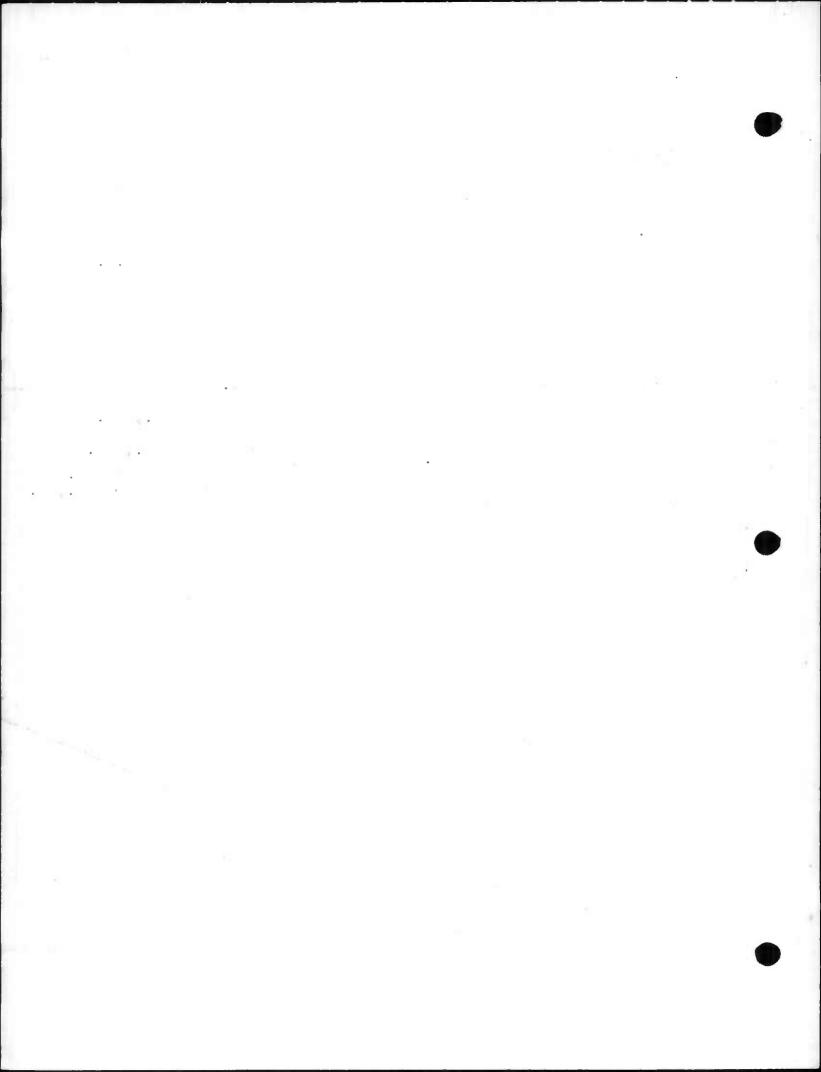


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any found and the death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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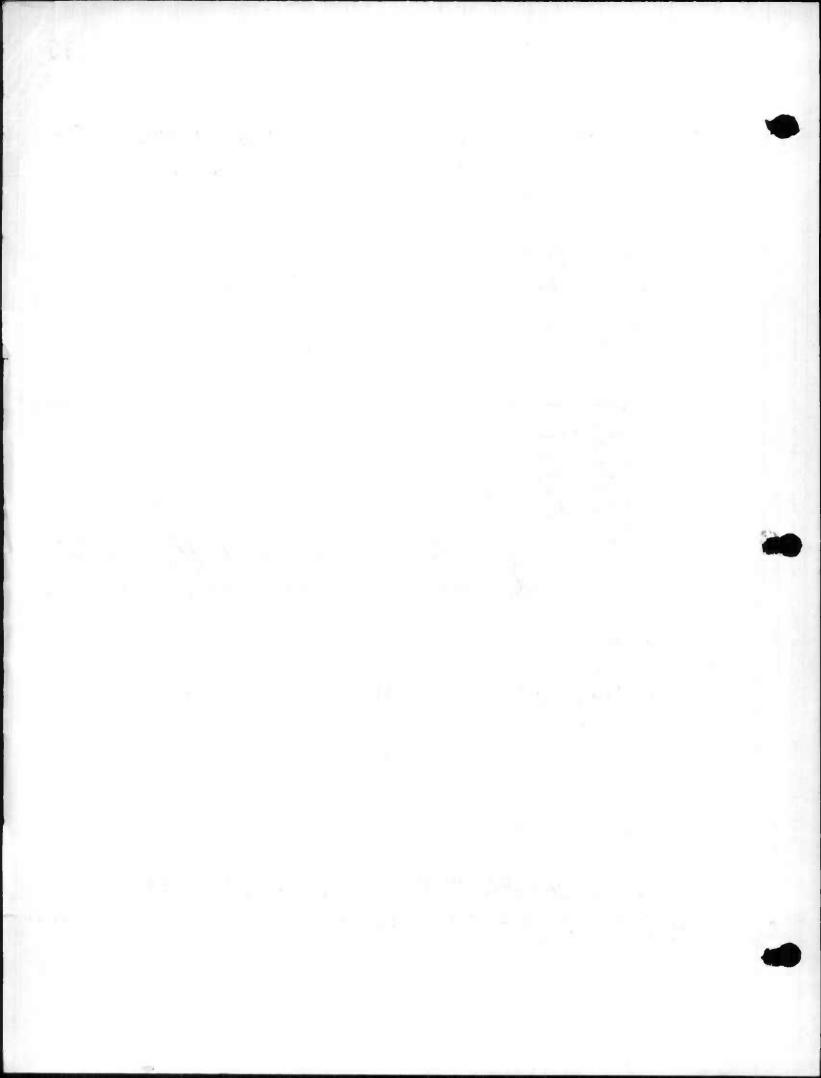
FOR STATE REGISTRAR

	REGISTRAN				CERTIF	ICALE	OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First								2. DATE O				3. TIME OF DEATH	
	Leon Me		Thompso	n					MONTH NOU'L	O	7	995	7.20 AM	
	4. SOCIAL SECURITY NUM	BER		6. AGE (In yr.	s. last birthday)	IF UNDER 1	YEAR	IF UNDER 24 HRS.	7. DAVE OF	BIRTN		8. BIRTH	PLACE (State or Foreign	
	214-76-8:	504	1 🕅 M 2 🗆 F	31	YRS.	MONTHS	DAYS	HOURS MIN.	(Month, 1	BIRTH 26-6	3	Countr	yland	
	9a. FACILITY NAME (If not it		reet and number)			9b. CITY,	TOWN C	OR LOCATION OF D				INTY OF D		
۳ ا	Union N	Momori	2] Hear	24.27							Su. 000			
DIRECTOR	RESIDENCE OF DE	CEDENT	al Hosp	rtal		B	dit	imore (City			N/A		
Ä	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OF	LOCAT	ION					10d. INSIDE CITY	
ă	MD.	N	I/A			В	alt	imore					LIMITS? 1 1 YES 2 □ NO	
	100. STREET AND NUMBER 1615 Abbottston Street 101. ZIP CODE 21218 102. CITIZEN OF WHAT U.S. a 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGINAL (Special Version No.) 14. PAGE 14.										IZEN DE W			
FUNERAL														
									fy Cuban, Maxican, Puerto Rican, etc.) Biack, Whit					
⊿											Specify: Black			
유	15. DEC	CEDENT'S EDUC	ATION	16a	. DECEDENT'S	USUAL OC	CUPATIO	ON .	18b K	IND OF BUS	INESC/IN	NICTOV		
	(Specify on Elementary/Secondary (ly highest grade (Completed) College (1-4 or 5 +)		(Give kind of ville. Do NOT us	work done during most of working use retired.)						3001111		
4	12th	J-12)	0 (1-4 67 5 +)		Cook					Restaurants				
COMPLETED	Cleveland inompson Laura A. Tapp								ME (Since Artic	dia Maida	Commo			
BE														
2	Laura Th		n		1615	Ahh	Ott	ston S	round Number, treet	Bal	t. O	MD	.21218	
		-		80.0								-		
												wn, State		
												7 N.Monro		
	Redd Funeral Service St Balt											lto.,MD.		
	26. PART I. Enter the d	Iseases, or c	omplications that	caused the	death. Do n	ot enter t	he mo	de of dying, suc	h as cerdis	c or respli	ratory an	rest.	Approximate	
	snock, or n	eert isliure. L	lst only one ceus	e on each	line.								Interval Between	
1	IMMEDIATE CAUSE (Findisease or condition	nei		ALD'	2								Onset and Death	
H	reaulting in death)	~ .		4 7 7 7 8	SEOUENCE OF	3.							24 hrs	
_//			502 10 (AINS	SECOENCE OF).							2 7000	
6	Sequentially list condit		DUE TO (OR AS A COL	SEQUENCE OF	n.							3/(0/)	
CERTIFICATION	If any, leading to Imme cause. Enter UNDERLY		2	2011/2	Ma-110	,							Edula	
윤미	CAUSE (Disease or Injuthat Initiated events		DUE TO (OR AS A COM	ISEOUENCE OF							Same		
FI	resulting in desth) LAS	er i	-			,.							i / I	
8 1		-											-	
	PART II. Other significe	ent conditions	contributing to d	leath but n	ot resulting I	n the und	erlying	csuse given in	Part I. 2	la. WAS AN		24b.	WERE AUTOPSY FINDINGS	
EDICAL										PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									_ '	U YES 2	YYNU		OF DEATH?	
Σ	DID TOBACCO U	ISE CONTR	IRLITE TO CAL	ISE OF D	EATH VE	s \square N		UNCERTAIL	NE				1 YES 2 NO	
CIAN:	25. WAS CASE REFERRED T		IDOIL TO CAC		LACE OF DEAT			ONCERIAII	A P I					
SIC	EXAMINER?	C POPO NO.	HØBPITAL:			OTHER:					_			
Ĕ	27. MANNER OF DEATH		28e. DATE OF II		28b. TIMI			5 Residence						
٠ ا	2	Pending	(Month, Day		INJ		Bc. INJI	RK?	28d. DEŞCR	IBE NOW IN	JURY OC	CURED		
à	E Passident	Investigation	20- 21 405 05	INI MIRON			1 🗆 Y							
		Could not be determined	28e. PLACE OF building, a	tc. (Specify)	t homa, farm, s	treet, factor	y, office			ON (Street a fown, State)	nd Number	or Rural Ro	oute Number,	
ш	01.660	107-10-11												
로Ⅱ	29a. CERTIFIER (Check only	TIFYING PHYSIC	CIAN: To the best of n	ny knowledge	, death occurre	d at the tim	a, deta	and place, and dua	to the cause	s) and man	ner as stat	ted.		
COMPL													and manner as stated.	
- 11	296. SIGNATURE AND TITLE		0					29c. LICENSE NUI						
H H	Markey	210	Kluis					^ ~ ^ 1	1200	110	DAI	YOU	(Month, Day, Year)	
2	30 NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CAUSE	OF DEATH	ITEM 273 /5mm	Print)		419	1204	76	- /	un	01/199	
	D 1-1-10	A		OF DENIN	ary (type,	rinn)	1/-	0 421		- 4	1 12	Vp		
	31. DATE FILED (Month, Day,	ATRE	J2. REGISTRAS	NY	1CHOK	IFIL	MC	SPITAL	. , 2	0/ E	VIO.	IV VA	eur, 189.18	



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, pours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely and in by the funeral director, page 5 should be detach as and within 20 hours after death with the State Dent, of Health and Mental Miciene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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withir	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely will in by the the second writting 25 hours after death with the State Dest, of Health and Mental Hyolene prior to burfal, cremation, or removal.	ent,
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FOR 1 - STATE REGISTRAR	STATE OF MAR		RTMENT OF H		MENTAL HYGIENE REG. NO.				
1. DECEDENT'S NAME (FIRST, BERTH	tA TI	LGHM	-		2. DATE OF DEATH MONTH DAY	199E	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 214 14 83	9 1 □ M 2 🔀 F	GE (In yrs. lest birthday) 85 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		909 Ma	BIRTHPLACE (State or Foreign Country) Maryland		
	itution, give street and number) Manor Nursing H	ome	Glen B	arnie	DEATH So. COUNTY OF DEATH Anne Arundel				
Maryland RESIDENCE OF DEC 10a. STATE Maryland	10b. COUNTY Anne Arundel		ry, town or Loca Len Burn				10d. INSIDE CITY LIMITS? 1 YES 2 X ND		
	oward Road		10		10g. CITIZEN OF WHAT COUNTRY?				
100. STREET AND NUMBER 7575 E. Ho 11. MARITAL STATUS 1 Never Married 2 01 3 W Widowed 4 01 100 01 10	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR O	ES 2 NO	if yes, sp		IIC ORIGIN? (Specify Year n, Puerto Rican, etc.)	or No— 14. RA Bio	CE - American Indian, seck, White, etc.		
Q 15, DECE	DENT'S EDUCATION highest grade completed) 12) College (1-4 or 5+)	(Give kind of life. Do NOT u	s usual occupati work done during m rese retired.) Operato	186. KIND OF BUSI	ness/industry				
W.	17. FATHER'S NAME (First, Middle, Lest) John Apple 18. MOTNER'S NAME (First, Middle, Maiden Surname) Annie Benjas								
P 199. INFORMANT'S NAME (7) Anna Gagl:			Redinond		Baltimore		land 21225		
20a. METHOD OF DISPOSITION 1 1 Burial 2 Cremation 4 Donation 5 Other	3 🗆 Removal from State	other place)	len Haven Memorial Park 5/22 Glen Burnie, Maryland						
21, SIGNATURE OF FUNERAL	SERVICE LICENSEE/	Dovis			Ce Funeral Hwy. Balti				
NO Sequentially list condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter UNDERLYII CAUSE (Disease or injusted initiated events resulting in death) LAS	ons, liste NG OUE TO (OR	AS A CONSEQUENCE O	OF):	lisc.	arshiz	Uma	mylite Seven		
PART II. Other algnifice WE STAND TO THE PART II. Other algnifice 25. WAS CASE REFERRED TO EXAMINER? 1	conditions contributing to dee		In the underlylr	ng ceuse given in	Part I. 24a. WAS AN PERFORI 1 YES 2	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL HOSPITAL: 1 Inpatient 2 ER	/Outpetlant 3 DOA	отныя:	PLACE DF DEATN (Ch					
27. MANNER OF DEATH 1 Netural 5	28e. DATE DF INJI (Month, Day, Y	JRY 28b. Til	ME OF 28c. IN	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED			
3 Suicide 8 4 Homicide		JURY — At home, farm, (Specify)							
cone)	IFYING PNYSICIAN: To the best of my CAL EXAMINER: On the basis of exami						e(e) and manner as stated.		
M GNATURE AND TIPLE	PERSON WHO COMPLETED CAUSE OF			D29	767	≥ 5 / 5	20 95		
TIPRE TUP YOUR COU	Sparbek,	M.D. 8	418	B+A.	B) Vd. Pa	sadin	K/Md2112		
MAT & 8 133.	0				<u></u>		DHMH-18 Rev 1/89		



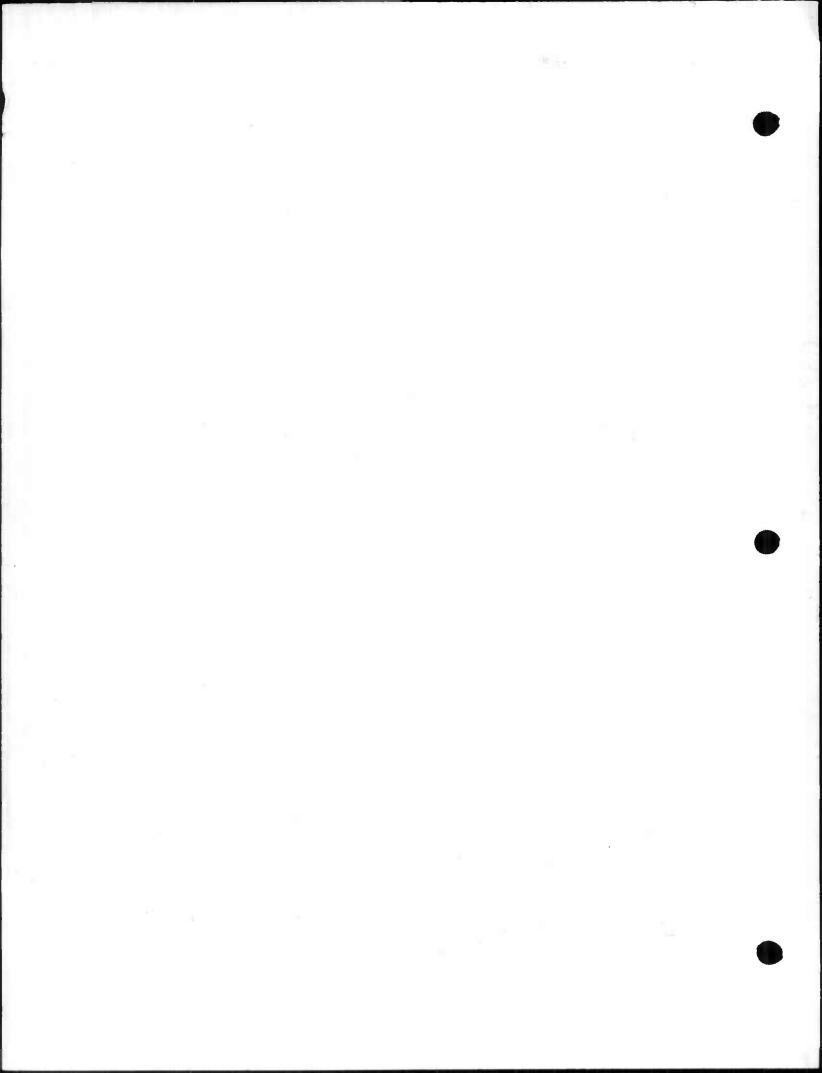
CIP

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

MAY 2 2 1995

		FOR STATE REGISTRAR	3. ZJ F	STATE OF I		ND / DE	PARTN		HEALTI	H AND		HYGIEN REG. NO.	E	0	1007
		1. DECEDENT'S NAME (First, GREER	Middle, Last)	KA	RIN			VOEG			2. DATE O	F DEATH	¥1995	YEAR	3. TIME OF DEATH 4:00 A _M
<u> </u>		4. SOCIAL SECURITY NUMB 048-48-4360	ER	5. SEX 1 M 2 F		yrs. lest birti	hday) IF	F UNDER 1 YEA	R IF UND	ER 24 HRS.	7. DATE O	BIRTH Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
2, 3 should	OR	99. FACILITY NAME (If not in #303 BRIS	STOL	*	RIVE		96. CITY, TOWN OR LOCATION OF DEA GAITHERSBUR					// 1.	TY OF DE		
permit. Pages 1,	DIRECTOR	10a. STATE Maryland	10b. COUNTY	gomery		10-	10c. CITY, TOWN DR LOCATION Gaithersburg							10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
S.	FUNERAL	303 Bristol	Downs	Dr.			101. ZIP CODE 20877						10g. CITIZEN DF WHAT COUNTY		
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. or removal. medical examiner must be notified at once.	ВУ	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X ND						ORIGIN? (Specify Yes or No— userto Ricar), atc.) 14. RACI Blaci Specific S			- American Indian, White, etc.
spital or atterned for use a	MPLETED		EDENT'S EDUI highest grade			(Give kii life. Do I	nd of work VOT use re		ATION most of work	king		Own F		USTRY	
ed by the hospits uld be detached ed at once.	BE COMPL	2 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Lest) Joseph Rogers 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
y be retained to age 5 should be notified	5	Helen Roge	rs			21	9 St	ageco	ach F		Avon,	CT	06001		
Page 6 may director, p		1 Buriel 2 Crematio 4 Donation 8 Other	n 3X Remo (Specify)		20b. F carnet RC	PLACE AND C tary, cremato DSE HI	y or other	place) Cemete	(Name of		5/22		cation – c		•
s after death. Page 6 may be by the funeral director, page emoval.		· A. Ge	MIL	alluli	30			ALTEI 6009	NBURG Harf	FUNE ord F	ERAL H	altin	ore,	MD	21214
E 8 = 5													Approximata interval Between Onset and Death		
be execute cian and co or to buria aumatic	ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury													
death certificate attending physic ental Hygiene pri	CERTIFI	that initieted events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE DF): d.													
te law requires that the deal has been signed by the att Dept. of Health and Merran 23 shows any Injury,	MEDICAL	PART II. Other significan								given in		48. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 PYES 2 \(\text{NO} \) NO
N: The law re icate has bee State Dept. o	SICIAN:	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			DEATH (C	Check only or		CERTAIN	1 🗆				
rSiCiAN: The certificate th the State d, or Item	主	XXYES 2 □ NO 27. MANNER OF DEATH		1 Inpatient 2 I	INJURY	284	OA 4 E	F 28c.	NJURY AT	lesidence	6 Other (S	Specify)	JURY OCC	URED	
ATTENDING PHYSICIAN: The ECTOR: After this certificate his after death with the State D 28 is marked, or item	D BY P	2 Accident	Pending nvestigation Could not be	FOUND(OF	5/16	/95 3: - At home, to	U MOURY 45 A erm, stree	M 1	WORK? VES 2	© (NO	UNK NOT	DN (Street a	nd Number o	or Rural Ro	oute Number,
Se Pour	PLETE	44- 4557-544	FYING PHYSIC	CIAN: To the best of		Fou	ND AT		ate end plac	e, end due	GAITHE	RSBURG	, MD.		DOWNS DRIVE
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I	COM		CAL EXAMINE	R: On the beels of s					, death occu		time, date er		d due to the	couse(s)	and menner se stated.
TO THE De filed	TO BE	30. NAME AND AODRESS OF		9/9	E DF OEAT	H (ITEM 27)	(Time Prin	nt)		C.M.					Month, Day, Year)
5		31. DATE FILED (Mopple, Oct.)	R	Fou	6-1	.11 P			eet,	Bal	timo	re, l	Mary	land	1 21201
i		MAY 2 2 199	15 A	32 HEGIS PIA	RIS INA										

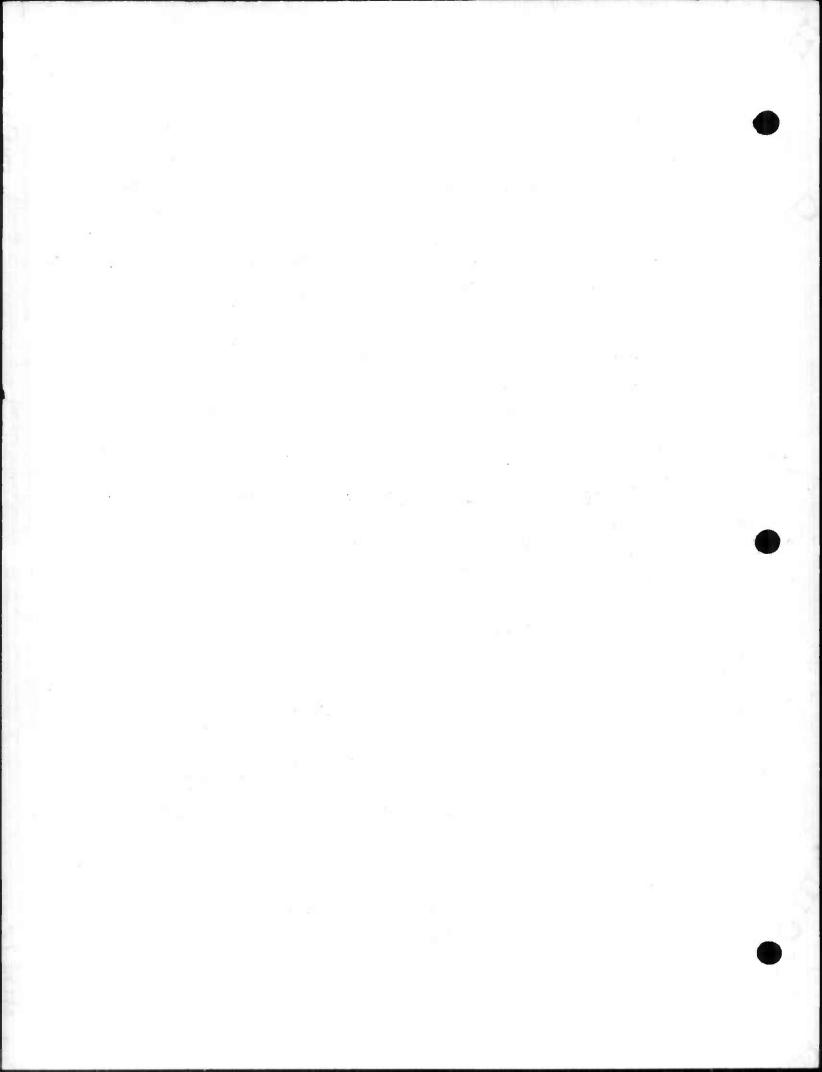


DIVISION OF VITAL RECORDS, P.O. BOX 68760

5+1

	FOR STATE	TATE OF MARY	/LAND / DEPAI	RTMENT OF H	EALTH AND	MENTAL HYGIEN	IE .				
	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO).				
	1. DECEDENT'S NAME (First, Middle, Lest) JEFFERY W	HITE				2. DATE OF DEATH MONTH MAY 1	7, 19 ⁵	3. TIME OF DEATH 10:37 AM			
	4. SOCIAL SECURITY NUMBER 5. S. S. S. S. S. S. S. S. S. S. S. S. S.	4	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)			
	9a. FACILITY NAME (If not institution, give street a	,	2	Sh CITY TOWN O	OR LOCATION OF D	1Hpe: 1 18	1962	Ma			
Œ	2123 CALLOW AVENU		↓ 1	1			9c. COUNTY	OF DEATH			
18	RESIDENCE OF DECEDENT	OE API.	† 1	BALTI	MORE C	T.T. A		i/A-			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	TY, TOWN OR LOCAT	ION			10d. INSIDE CITY			
	Hd NI	<u>A</u>	6	saltin	ole			1 YES 2 NO			
₽ Z	100. STREET AND NUMBER	A	1, 6	101.	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
Ä	The street and number 2123 Callow Ave. 1st. floop 21217 11. Marital status 1. Never Married 2 Married 12. Was Decembert ever in u.s. armed 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 14. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Specify Vee or No. 16. Race — American In 15. Was Decembert of Hispanic Origin? (Spec										
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3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
Ë	Wille. Do NOT use relired.)										
E E	12th Guard Md. House of Coelectron 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Last)										
BE CC	William L. W	shite			Lillia		mitt				
2	198. INFORMANT'S NAME (Type/Print)	te	2.12.3	ADDRESS (Street at	nd Number or Rural	Route Number, City or Tow	m, State, Zip Co	D. 21217			
	29a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 29a. LOCATION — City or Town, State										
	1 Donation 6 Other (Specify) 1 DONALL COM. 52595 WINGS MILLS MC										
1	21. SIGNATURE OF TUNERAL SERVICE LICENSE	E D		23. NAME AN	TUNE	CILITY Home-C	Urst 1	21215			
	* Dunus	10.7	cott	4300	Wako	who Arre.	Dalt	0. Md 21215			
	23. PART I. Enter the disease, or compilections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate integral Returns.										
1 1	anock, or ham railure. List only one cause on sech lins. IMMEDIATE CAUSE (Final Onset and Death										
1 1	ella a a a a a a a a a distant										
	ella a a a a a a a a a distant	ENTRAOR			DOUND						
	ella a a a a a a a a a distant		A CONSEQUENCE O		OUND						
NOI	disease or condition resulting in death) Sequentially list conditions,	DUE TO (OR AS		F):	DOON						
CATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	F):	00000						
IFICATION	Sequentially ilat conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	F):	0000						
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS	S A CONSEQUENCE O	F):	0000						
0	Sequentially ilat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	B A CONSEQUENCE O	F):		Part I 24a WAS AN	AITTOPEY	Onset and Death			
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BE COMPLETED BY PHYSICIAN: MEDICAL C	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTED TO MEDICAL EXAMINER? 1 Netural 5 Pending Investigation 22. MANNER OF DEATH 1 Netural 5 Pending Investigation 24 Could not be determined 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	DUE TO (OR AS DUE TO	S A CONSEQUENCE OF A CONSEQUENCE OF DEATH YIELD A CONSEQUENCE OF DEATH YIE	F): F): In the underlying TH (Check only one) OTHER: 4 Nursing Home E OF 28c. INJURY UND 1 Y. WOF street, factory, office	UNCERTAIN Wignesidence JRY AT RK7 ES 2 NO and place, and due beth occured at the 29c, LICENSE NUK	6 Other (Specify) 28d. DESCRIBE HOW I 28t. LOCATION (Street City or Town, State) 21 2 3 Auculation (Street Autumn, data and placa, and main time, data and placa, and MBER	NJURY OCCURION S LONG STATE OF THE PROPERTY OF	Onset and Death 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO ED SUFF Rurel Route Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE Number, DATHORS WITH ROUTE NUMBER, DATHORS WITH ROUTE NUM			
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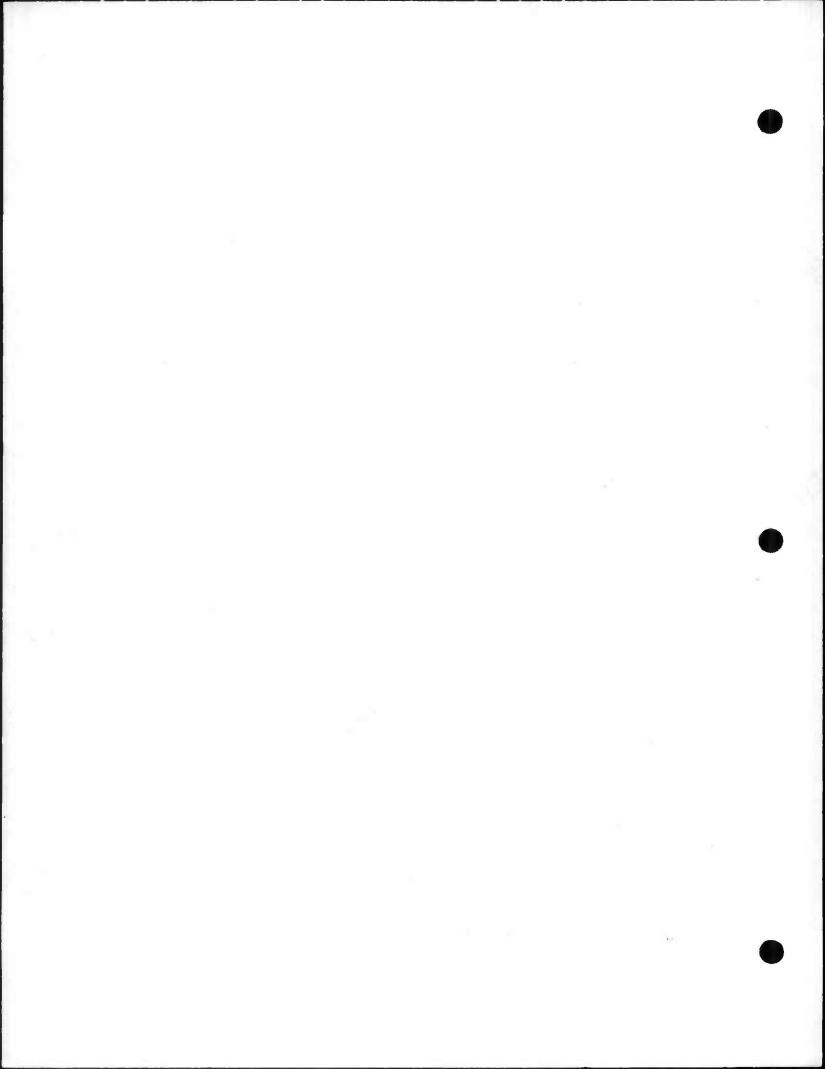


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		FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPART	MENT OF	HEALTH	AND MI	ENTAL HYGIE					
		1. DECEDENT'S NAME (First, Middle, Last)						- 1	2. DATE OF DEATH			3. TIME OF DEAT	TH .	
		Ruby Mae	WHITI	AKER					May 16,1	995	YEAR	8:10 P		
		4. SOCIAL SECURITY NUMBER		(In yrs. lest		IF UNDER 1 YEA		R 24 HRS. 7	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI Count	IPLACE (State or Fo	reign	
무		414 40 1729	1 🗆 M 2 😾 F	68	YRS.	OHINS DA	A HOURS	MIN.	Sept. 15	,1926				
3 should	000	9e. FACILITY NAME (If not institution, give				9b. CITY, TOV	YN OR LOCATI			9c. COU	NTY OF D	EATH		
1, 2, 3	흔	Franklin Square H	<u>ospital Cente</u>	er		R	Rossville Balt					re		
Pages 1	DIRECTOR	10e. STATE 10b. COUNT				TOWN OR LO	CATION				10d. INSIDE CITY			
. 	<u>=</u>	Maryland Balti	lmore		Es	sex					LIMITS?			
permit.	FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?		
an. ransit	岁	922 Middlesex Roa					2122				U.S	.A.		
1215-0020 r attending physician. use as the burial-transit	5	11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1 YES	FORCES? 1 YES XX NO				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify V If yes, specify Cuben, Mexican, Puerto Ricen, atc.)				E — American Indie k, White, etc.	m,	
	B	3 ☑ Widowed 4 ☐ Divorced	IF YES, GIVE WAR OR D	ATES		10	YES 2 100	Specify:			Specify White			
	<u> </u>	15. DECEDENT'S ED	UCATION	15e. DEC	EDENT'S U	SUAL OCCUP	ATION		16b. KIND OF B	USINESS/IND		1111200	_	
21 for u	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille.	Do NOT use	retired.)	most of workli	ng						
AND the hospital detached to	COMPL	Unknown		Ho	usewi	fe			Ho	me				
iE, MARYLA sy be retained by the page 5 should be det be notified at on	5 8	17. FATHER'S NAME (First, Middle, Last)							(First, Middle, Meidl	n Sumame)				
		James Gibso	on				Jevena Eller							
	2	19 190 INFORMANT'S NAME (Ima/Print)												
		20e. METHOD OF DISPOSITION			_	DISPOSITION		Balt		arylai ocation —				
O ∞ €	100	1 1 Buriel 2 □ Cremetion 3 □ Rer 4 □ Donetion 5 □ Other (Specify)	novel from State	netery cren	natory or othe	mer place)	Garde	ne 5/	20/95 Ba	ltimo	City or ic	Mass	.1 ->	
		21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		1	22. NAME	AND ADDRE	SS OF FACIL	meral Ho	LCINO	Le C	J., Mary	Tai	
4 8 2	a craiming	Jan Z	Bungles	und	E							1 10		
after on the state of the state		23. PART i. Enter the diseases, or	complications that cause	d the dea	th. Do no	1407	mode of dvi	ern Av	ve Balti	more.	, MA	PAPPROXIMA	_	
hours ed in b		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final											twee	
y fill		diagon or any distance										Onset and	Daat	
with mplete crem	event,	resulting in death) o. Cuile 190 Cauleal Bracking DUE TO (OR AS A CONSEQUENCE OF):											04	
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the atter			d	-										
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uires that signed Health a	MEDIC								_ 1 _ YES	2 NO		COMPLETION OF CO OF DEATH?	AUSE	
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has t	AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE O	_		(Check soly o		ERTAIN						
_ F 2 % ;		EXAMINER?	HOSPITAL:		- 0	THER:								
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St.	PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY	MICHETY 3	28b. TIME (OF 28c.	INJURY AT		Other (Specify) Bd. DESCRIBE HOW	INJURY OC	LIBED			
r this	ВУ Р	1 Natural 5 Pending	(Month, Day, Year)		INJUR	TY	WORK?				0.120			
NDING I	ED B	2' Accident investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At hom	ne, form, atre	et, factory, o	ffice	28	Bf. LOCATION (Stree	end Number	or Rural F	loute Number,	_	
DR ATTENDING DIRECTOR: After hours after death		4 Homicide determined		,					City or Town, Stat	")				
L DIREC	12	290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	ledge, des	th occurred	at the time, d	late end place,	end due to	the cause(e) end m	enner as stat	ed.			
HOSPITAL FUNERAL WITHIN 72			ER: On the beele of examination) end manner ee st	ated.	
THE HOSPITAL THE FUNERAL filed within 72	E O	296 AGNATURE AND TITLE OF CERTIFIE	111.00	1			29c, LICE	NSE NUMBE	RD 2.	29d. DAT	SIGNED	(Month, Day, Year)	_	
55%	0 B	freux 1)	ogece,	1	uns		10	260	150)	5/1	7/85		
		MAME AND ADDRESS OF DEDSON WI	IO COMBIETED CAUSE OF 42	ATIL OTES	AT (T -								_	

Paul Valle 9000 Frankin Square DR. Baltimore, Maryland 21237

III. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

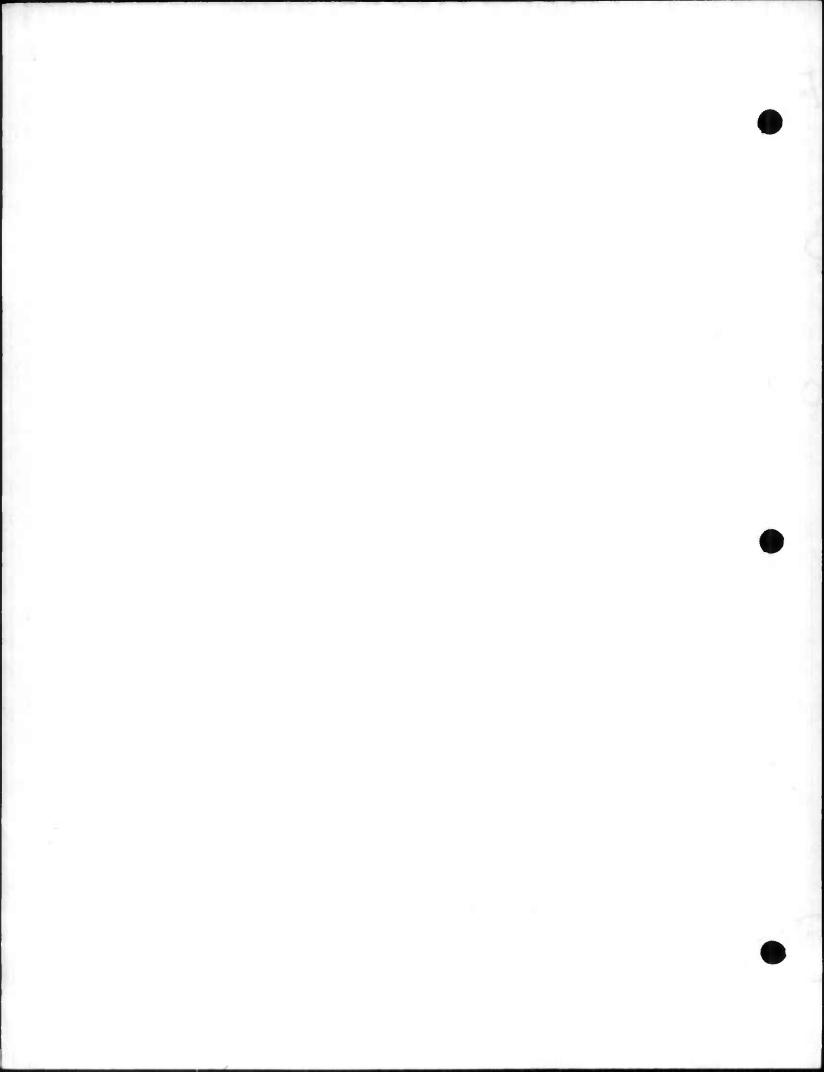
TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First	Middle, Last)						-		2. DATE O	F DEATN		1	3. TIME OF DEATN
	Eth						MONTH DAY Y			YEAR	_			
i	Ethel Fanning White 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. les				st birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.						1:00 P. M		
	339-50-7385		1 M 2 X F	96	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Ybar)	000	Country)
	9a. FACILITY NAME (If not in		eet and number)	70		9b. CITY	, TOWN	OR LOCATI	ON OF DE	May	19, 1		B Illinois	
E C	Wilson Health Care Center					G	aith	ersb	1120					
DIRECTOR	RESIDENCE OF DECEDENT								urg			M	ontgo	mery
2	10a. STATE 10b. COUNTY					10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?		
	N/A N/A				h	Washington, D.C.					1 🔀 YES 2			1 X YES 2 NO
RA				101	. ZIP COD				HAT COUNTRY?					
FUNERAL	3114 Wisco		venue, 1						016					States
	1 Never Married 2		FORCES? 1	YES 2 X	NO	If yes, specify Cuban, Mexican, Pu					ORIGIN? (Specify Yes or No.— 14. RACE — A Puerto Rican, etc.) 14. RACE — A Black, Wh			- American Indian, White, atc.
BY	3 🔀 Widowed 4 🗌 Divo	rced	IF YES, GIVE V	WAR OR DATES		1 TYES 2 X NO Specify:					Specify:			White
COMPLETED	15. DEC	EDENT'S EDUCA	ATION	16a. D	ECEDENT'S	USUAL O	CCUPATIO	ON		18b. F	(IND OF BUS	INESS/ING	DUSTRY	WIIICC
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	+) ///	Give kind of e. Do NOT u	work done se retired.)	during mo	st of worldi	ng					
MP	12				Home	make	r				Owr	Hon	ne	
8	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	NER'S NA	ME (First, Mic	ddle, Maiden	Surname)	1,1	
BE			anning								Len E			
2	19a. INFORMANT'S NAME (7	rpe/Print)		19	b. MAILING	ADDRESS	S (Street s	and Number	or Rural F	Route Number	City or Town	, State, Zip	Code)	
	Mary Whit				1241				, N.	W., V	Vashir	igton	, D.(C. 20007
	20e. METHOD OF DISPOSITE 1 Street 2 □ Cremetic	n 3 🗆 Remov	ral from State	20b. PLACE cemetery, cn						DATE			City or Tow	
	4 ☐ Donation 5 ☐ Other 21 SIGNATURE OF FUNERA		Nete	St. C	Colum			ery O ADDRE		4/1	7 Ot	tawa	, Ill	inois
		(1),00		22.	NAME A	AD ADDRE	SS OF FAC	De	eVol 1	Funer	cal H	ome
	1 vice	vant	11-6	relie	M	10	E.D	eer	Park	Dr.,	Gait	hers	burg,	MD. 20877
	23. PART I. Enter the di shock, or he	sesses, or co eart failure. Li	mplications that ist only one ceu	t caused the deservation	eeth. Do r	not enter	the mo	de of dy	ing, auci	h ss cerdis	c or respli	ratory sri	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Fin	al				Onset and Death								
	disease or condition	→ a.	CORO	nary	Ax	721	cy.	Dis	SAA	0/				
			DUE TO	(OR AS A CONSE	OUENCE O	F):	/							
ON	Sequantially list conditions, b													
AT	If any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or Inju	ry C	DUE TO	(OR AS A CONSE	OUENCE O	F):								
E	reaulting in death) LAS	r L												
	5455 # SH + #	0.												1
MEDICAL	PART II. Other aignifice		*	0	resulting	in tha un	deriying	ceuse (given in	Part I. 2	4a. WAS AN A			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Organi		am 5	indro	me	_				1	YES 2	X NO		COMPLETION OF CAUSE OF DEATH?
- 1	Chron		TI '										1	YES 2 NO
AN	DID TOBACCO U		BUTE TO CA					UNC	ERTAIN	1 🗆 📗				
PHYSICIAN:	EXAMINER?		HOSPITAL:		CE OF DEAT	OTHER	1 :							
¥	1 YES 2 NO		1 Inpatient 2 I		28b, TIM		28c. INJ		sidence	6 Other (241200	
	1 🖾 Netural 5 🔲	Pending nvestigation	(Month, D.			URY	WO	RK?						
BÁ	2 - 0-1-14-	ome, ferm, a	street, fect			110	281 LOCAT	201 LOCATION (Company)						
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, Steet) 28s. LOCATION (Street and Number or Rural Route Number or									ore Number,				
9	29a. CERTIFIER 1 K CERT	EVINC BUVEICI	AN. To the heat of							due to the cause(s) and manner as stated,				
COMPLETED														and manner as stated.
			> X	-	7		panon, o							
8	29b. SIGNATURE AND TITLE	7(7	-	2000	/			29c. LICE	NSE NUM	358	1			Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHA	COMPLETED CALIS	SE OF DEATH IT	M ZEP COUR	Print		V			1	F	Apr11	19, 1995
	Elliot R. Go				27-5077.7	100000	+	D -	- ا) _ _ L		(a 1	- 1 ·	0001/
- 1	31. DATE FILED (Month, Day,			9410 O	TO GE	orge	LOWI	ı KOS	ia, I	oetnes	saa, N	aryl	land 2	20814
	MAY 17	1905	Kli: As	des Rad	40									
		4 7 7 7 7	MILLA DINING	WARD TO BE DATE	#Z									



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BALTIMORE, MARYLAND 21215-0020 executed

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wilson YEAR WRIGHT mau WOODROW 10:25 PM D 95 7. DATE OF BIRTIN
(Month, Day, Year)
1912 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 229-01-6700 1 XH 2 F 82 DAYE Virginia should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN Sc. COUNTY OF DEATN DIRECTOR Baltimore City Pages 1, 2, 3 Johns Hopkins Bayview Medical Ctr. N/A RESIDENCE OF DECEDENT 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maruland Baltimore Dundalk 1 YES 2 XNO permit. 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7931 Eastdale Road 21224 funeral director, page 5 should be detached for use as the burial-transit United States retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 9 Years Machinist Aerospace Industry 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) 75 J. P. Wright Cornelia Hopkins BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carolyn A. Wright Eastdale Road Dundalk, Maryland hours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Oak Lawn Cemetery May 20, 1995 4 Donation 5 Other (Specify) Baltimore. Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc. redo 7922 Wise Ave. Dundalk, Maryland the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or twent failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition DUE TO (OR AS A CONSEQUENCE OF): ARREST event, resulting in death) 24 how DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CORONARY ARTERY DISEASE YCARS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART ii. Other algnificent conditione contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the that any MELLITUS DIABETES 1 TYES 2 TENO OF DEATH? Shows 1 | YES 2 | NO L of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has by Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h the State (HOSBITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d, DESCRIBE NOW INJURY OCCURED this (1 Natural 5 Pending м 1 YES 2 NO After the BY 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Sulcide 69 ETED. 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) OIRECTOR: / 6 Could not be 82 4 Nomicide determined hours 29e. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL (Check only one) TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If I HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE m163 orton 5 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BANIEW MEDICAL ANNE 老 MOHE CENTER MD 31. DATE FILED (Month, Day, Year) REGISTRAN'S SIGNATURE MAY 22 1995

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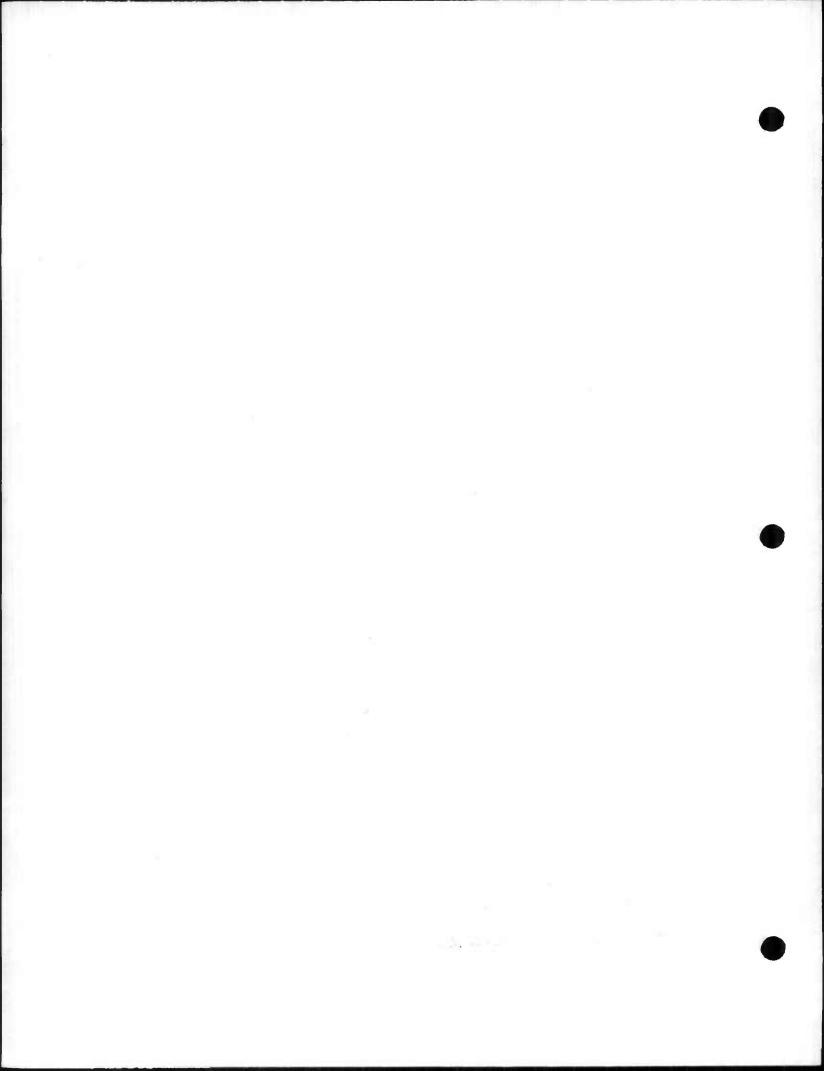
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - STATE REGISTRAR	OTALL OF MARTIE	AND / DEPAR CERTIF	IMENT OF	HEALIH AND F DEATH	MENTA	IL HYGIE REG. N					
	1. DECEDENT'S NAME (First, Middle, Last)						E OF DEATH			TIME OF OEATN		
	Leona	Rita	Wesse	1		Mav			YEAR	10:30		
	4. SOCIAL SECURITY NUMBER 216-32-0098		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DAT	OF BIRTH			CE (State or Forei		
		1 🗆 M 2🏝 F	83 yrs.			Feb		1912	1	Maryla		
œ	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF	DEATN		9c. COUNT	Y OF DEAT	N		
CTOR	South Rolling	Road 1524		Re]	elay Bal					timore		
DIREC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
	Maryland	NA	Bal	timore	9				15	LIMITS? YES 2 N		
FUNERAL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WE											
JNE	Malvern Street	1710	N II S ADMED	40, 140, 04	21224 ECENDENT OF HISPA			Unite				
	1 Never Married 2 Married	FORCES? 1 YES	2 XNO	If you, a	specify Cuban, Maxic	an, Puerto	N7 (Specify Y Rican, etc.)	ea or No 1	Black, W	American Indian, hite, etc.		
BY	3 Wildowed 4 Divorced	ii teo, cive tom on p	on Ea	1 ""	S 2 NO Spec	any:			Specify:	White		
ED	15. DECEOENT'S EDU (Specify only highest grade	JCATION e completed)	16a. DECEDENT'S (Give kind of w	rork done during n		16	b. KIND OF B	USINESS/INDUS				
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	,								
COMPL	17. FATNER'S NAME (First, Middle, Lest)	NA	cafete	ria ca	shier	B	alto	Count	y Sc	hools		
ECC	John J. Ad	lama.			18. MOTNER'S N		Middle, Maide					
00	19s. INFORMANT'S NAME (Type/Print)	lallis	19b, MAILING	ADORESS (Street	Tina		nber, City or To		insk	<u> </u>		
2	Margaret Bever	ungen			Rd. 152							
	20a. METHOD OF OISPOSITION 10.1 Burial 2 Cremation 3 Rem	200	D. PLACE AND OATEO	FOISPOSITION (DA		OCATION CH				
	Sacred Heart of Mary May 23 Dundalk Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. Dabrowski/Chojnacki F.H. P.A.											
	23. PART I. Effer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	IMMEDIATE CAUSE (Final disease or condition resulting in death)		COM		100000000000000000000000000000000000000					Onset and t		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
7. 1	PART II. Other significant condition	na contributing to death b	out not resulting in	n the underlyin	ng cause given ir	Part I.	24s. WAS A	N AUTOPSY	24b, WE	HE AUTOPSY PIND		
MEDICAL	PERFORMEDY 1 □ YES 2 (3000									MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH			ΝЦ						
A	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outs		OTHER:	La contraction of the con-							
SICIAN	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		passerii - S-C, Franci	OF 26c. IN	me 5 X Residence		The second second	INJURY OCCUP	RED			
HYSICIAN	1 ☐ YES 2 XNO 27. MANNER OF DEATH	28s. DATE OF INJURY	20b. TIME	RY WORKY 28d.1			ni otsonine now mount occured					
	27. MANNER OF DEATH Manual 5 Pending	-	20b. TIME INJU	A CONTRACTOR OF THE PARTY OF TH	YES 2 NO							
D 84	27. MANNER OF DEATH Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year) 28s. PLACE OF INJURY	/ — At home, farm, st	M 1 🗆		28f. LOC	ATION (Street	and Number or	Rural Route	Number		
TED BY	27. MANNER OF DEATH The Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Mooth, Day, Year)	/ — At home, farm, st	M 1 🗆		28f. LOC City	OFFICE (Street or Town, State	and Number or I)	Rural Route	Number		
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ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSIC	THE FUNERAL DIRECTOR: After this cer	filed within 72 hours after death with th	PORTANT: If item 28 is marked, i
-	-	۵	-

										9	5	15680
	1 - FOR STATE REGISTRAR	STATE OF MA		DEPAR					MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, MICHIG, Lest) MATTIE WHITE								2. DATE OF DEATH BONTH D	ar 1th lo	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-24-5944	1 🗆 M 2 🙀 F	. AGE (In yrs. I	3 9 vns.	MONTHS	DAYS	AVE HOURE MIN			e of BIRTH (ch, Day, Year) AR. 22, 1906 VI		PLACE (State or Foreign) GINIA
TOR	NORTHWEST ME	NTER		9b. CIT		DR LOCATIO	ON OF DE	АТН	BALTIMORE CO.			
BE COMPLETED BY FUNERAL DIRECTOR	10s. STATE 10b. COUNTY MARYLAND N		10c. CI1	10c. CITY, TOWN OR LOCATION BALTIMORE CITY							10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
	1205 N. CURLE		1 21213						ZEN OF WHAT COUNTRY?			
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	EVER IN U.S. A YES 2 T OR DATES	RMED NO	13. WAS DECENDENT OF NISPANIC ORIGIN? If yes, specify Cuben, Mexican, Puerto Ri 1 YES 2 NO Specify:					s or No—	14. RACE Black, Specify	- American Indian, White, etc.	
	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	(Give kind of fe. Do NOT u	work done ise retired.)	during mo	LONDON TOWN					5	
	6TH N/A SEAMSTRESS MANUFACTURERS 17. FATHER'S NAME (First, Middle, Last) RICHARD BARTEE LAURA BOOKER											
2	199. INFORMANT'S NAME (Type/Print) CYNTHIA JOHNS	1	7119 MINNA ROAD BALTO, MD. 21207									
	20e. METNOD OF DISPOSITION 1 © Burial 2 Cremation 3 Rer 4 Donation 8 Other (Specify)	20b. PLACE cemetery, cr BALT	PLACE AND DATE OF DISPOSITION (Name of lefty, cremetory or other place) ALTIMORE CEMETERY 5/25/95 BALTO, MD.								vn, State	
	21/SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213											
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory and abook, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											Approximate interval Between Onset and Death
RTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
	CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PHYSICIAN: MEDICAL CE	PART II. Other algnificent condition	ne contributing to de	eath but not	reaulting	in the u	nderlying	g cause g	liven in	Part I. 24a. WAS AN PERFOI	RMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ОТНЕ		ACE OF D	EATN (Chi	ok only one)			
PHYS	1 YES 2 NO 27. MANNER OF DEATN	1 Inputient 2 E	JURY	28b. TIN	4 □ Nu	rsing Hom 28c. INJ		sidence	6 Other (Specify) 28d, DESCRIBE NOW I	NJURY OCC	URED	

Inpatient 2 ER/Outpatient	3 DOA 4 Nu	R: rsing Home 5 Rasidence	6 ☐ Other (Specify)
28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED
28e. PLACE OF INJURY At h building, etc. (Specify)	ome, farm, atreet, fac	etory, offica	281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)

29c. LICENSE NUMBER

1 CERTIFYING PNYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated.

2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

K.S.RAO.M.D 4346 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

K.S. RAO, MI.O NORTH VEST RANDALLS CENTER

32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

2 2 1995

8 Could not be determined

27. MANNER OF DEATN 1 Netural
2 Accident

3 Suicide

4 Nomicide

BY

TO BE COMPLETED

19th, 1995

29d. DATE SIGNED (Month, Day, Year)

MIA

D. D. Denner S. W. State S. S. Talk

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours effer death. Page 6 may be retained by the host TO THE FUREAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Merital Hyghere prior to build, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MAR		DEPAR				MENTA	HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH			3. TIME OF DEATN		
	Scott	David		Z	CORN			Ma	1 /		95	11:38	p^{M}	
	4. SOCIAL SECURITY NUMBER 218–54–2726	5. SEX 6. A	35	lest birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATI	of BIRTH	60	BIRTH Count Ma	ryland	reign	
~	So. FACILITY NAME (If not institution, give s						R LOCATION OF DE	EATH		9c. COU	NTY OF D	DEATH		
DIRECTOR	Franklin Square	Hospital			Ba	iltin	nore			Ba1	timo	re Coun	ty	
EC	10a. STATE 10b. COUNT				Y, TOWN O							10d. INSIDE CITY		
		rd County		1	Ellic	cott	City					1 TYES 2	NO	
FUNERAL	100. STREET AND NUMBER 4512 Yorkshire Dr	ive				10f.	2104	3		10g. CITI	USA	WHAT COUNTRY?		
JNE	11. MARITAL STATUS	12. WAS DECEDENT EVI	ER IN U.S.	ARMED	13. V	MAS DECE	ENDENT OF HISPAN		IN? (Specify Ver	or No.		E — American India		
BY	1 Never Married 2 Never Married 3 Divorced	FORCES? 1 1 Y	YES 2X	□ (NO	11	yes, spe	cify Cuban, Maxica	n, Puerto	Rican, atc.)	U NU	Blac	k, white, atc.	ro,	
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relied.) 16b. KIND OF BUSINESS/INDUSTRY													
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) Vice—President Tele—Serve Corp									moration				
JMF											POLACION	_		
TO BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street an	d Number or Rural i	Route Nun	nber, City or Tow	n, State, Zip	Code)			
F	Ms. Kim Zorn						e Dr., E	llic	ott Ci	ty,	MD 2	1043		
	20e. METNOD OF DISPOSITION 1 Burlal 2 XCremation 3 Rem	ovel from State	20b. PLAC	CE AND DATE (crematory of o	or bisposi (her place)	TION (Nan	ne of	DA		CATION —				
	4 Donation 6 Other (Specify) Partimore Washington Crematory 5/20/95 Laurel, Mary 21. SIGNATURE of FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A.										Marylan	a		
	23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.													
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition													
	disease or condition resulting in deeth) a. Aortic Rupture and Pericardial Tamponade													
	a. AOFLIC RUPTURE and Pericardial Tamponade 1 hour Due To (or As A CONSEQUENCE OF): Sequentially list conditions.													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	OI A	SCENdi SEQUENCE OF	ng A	orta	, probab	ly :	syphili	tic_				
CAT	cause. Enter UNDERLYING	c												
III.	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):													
CEF	and a constant of the constant	d												
CAL	PART II. Other significent condition	es contributing to deal	th but no	ot resulting i	n the und	derlying	cause given in	Part i.	24s, WAS AN PERFOR		24b	. WERE AUTOPSY FIR AVAILABLE PRIOR 1		
MEDIC								_	1 X YES 2	□ NO		OF DEATH?	WSE	
M	DID TOBACCO USE CONT	DIRLITE TO CALLE	E OF D	CATLL VE	c 🗆 🔪	10 E	LINICEDTAIN					1XXYES 2 N	0	
IAN	25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE		ACE OF DEAT			UNCERIAII	и Ц						
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	Outpatient	3 DOA	OTHER		5 🗆 Residence	6 🗆 Oth	er (Specify)					
PHYSICIAN:	27. MANNER OF DEATH	26s. DATE OF INJU (Month, Day, Yo.		26b. TIM		28c. INJU WOR	RY AT		SCRIBE HOW II	NJURY OCC	URED			
ВУ	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 NO							
	3 Suicide 6 Could not be determined	28e. PLACE OF INJ building, atc. ((Specify)	nome, farm, s	dreet, facto	ry, office			CATION (Street a r or Town, State)	ind Number	or Rural F	Route Number,		
COMPLETED	29a. CERTIFIER 1 X CERTIFYING PHYSI	CIAN: To the best of my k	nowledge	death occurre	of of the sie	ne data -	and place, and dire	to the c	unada) cad a: -					
294. CERTIFFIER 1 1 CERTIFFIER 1 1 CERTIFFIER PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as state									rted.					
BE C	296. SIGNATUSENAND TITLE OF CERTIFIE	m	0				29c. LICENSE NUM		2			(Month, Day, Year)		
TO B	Mult	ellan	be	M			0/49	1%	3	▶ 5	/	495		
	30. HAME WHO ADDRESS OF PERSON WH													
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BALTIMORE, MARYLAND 21215-0020

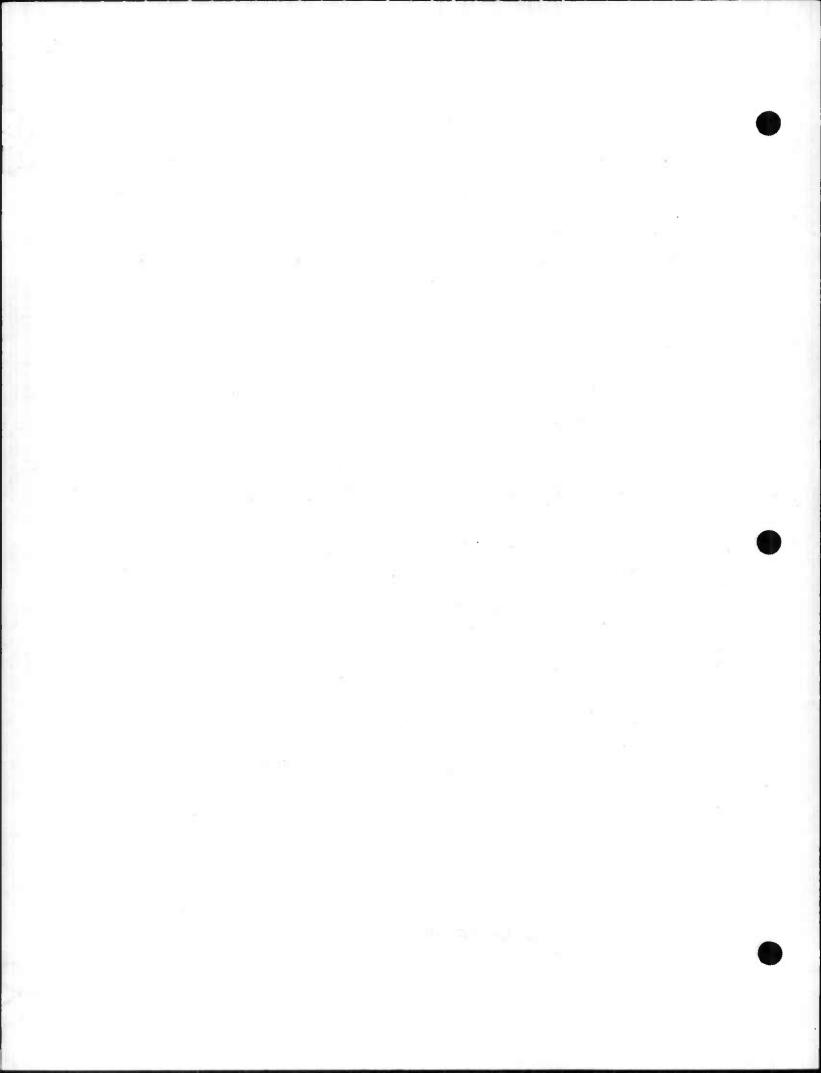
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1. DECEDENT'S NAME (First, Middle, Las.	(i)	Ze	lake			2. DATE OF OEATH MONTH	DAY	YEAR GGT	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER		E (In yrs. les	t birthday) IF U	IDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Country	**	
pino		178-30-3622 90. FACILITY NAME (If not institution, given			1000	HTY TOWN	OR LOCATION OF D	July 8 19		Pen NTY OF O	nsvivania	
2, 3 should	DIRECTOR	Howard County Ga	neral Hospit	a1		co1ur			100	ard	LAITI	
ges 1,	3EC	10a. STATE 10b. COU	YTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY	
			ard		Colu	nbia					1 YES 2 NO	
physician, burial-transit permit, Pages	FUNERAL	100. STREET AND NUMBER 7146 Talisman I	n.			101. ZIP CODE 21045	10g. CITIZEN OF W			THAT COUNTRY?		
	BY FUN	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 P	MED	it yes,	ECENDENT OF HISPAI specify Cuben, Mexico ES 2 NO Specif	cen, Puarto Rican, etc.) Black, Wi Specify:				
r attending use as the	8	15. DECEOENT'S E	DUCATION	16a. DE	CEOENT'S USUA	L OCCUPA	TION	16b. KIND OF B	USINESS/IN	Whi	te	
al or	COMPLET	(Specify only highest gri Elementary/Secondary (0-12) 1.2	College (1-4 or 5+)	(G life.	be kind of work do Do NOT use retin Secreta	d.)	most of working	Johns	Hopki	ns U	niversity	
by the hospit be detached at once.	OM	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NAME (First, Middle, Meiden Sumerne)					
be d	ш	Raymond Dillo	n				Dortha	,				
5 should notified	0 8	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, S										
y be re lage 5	F	Meredith Zeigler 7146 Talison Ln. Columbia, Md. 21045										
e 6 may ector, pa must b		20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State										
Page Il direc		4 Denetion 5 Other (Specify) Balt—Wash Crematory Inc 5-120-99 Tallrel, Md.										
death. funera		· allen A	M005	44		S1a	ick Funera	al Home, F				
wecuted with	TION	IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate	a. DUE TO (OR AS OUE TO (OR AS	A CONSEC	SQUENCE OF):		11	Dreinsmb Luny			Approximate Interval Betwee Onset and Dei	
th certificat ending phy il Hygiene p or other	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST DIE TO (OR AS A CONSCIUENCE OF): d. PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FIND										
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N: The Infrare has State De	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			IER:	ome 5 - Reeldence	à 🗆 au - 10 - 11 -				
ATTENDING PHYSICIAN: The ECTOR: After this certificate his after death with the State C 28 is marked, or Item	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigatio	26a. DATE OF INJURY (Month, Day, Year,	Y	28b. TIME OF	26c. II	NJURY AT VORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OC	CURED		
OR ATTENDING DIRECTOR: After hours after death item 28 is mail		3 Suicide 6 Could not b	26e. PLACE OF INJUI building, atc. (Sc	RY — At ho	me, ferm, street,	factory, off	Nce	281. LOCATION (Stree City or Town, Stat	end Number	or Rural R	oute Number,	
Z 3 2 =	COMPLETED		SICIAN: To the best of my known NER: On the bests of exeminat) end menner se stated	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	TO BE C	206. SHOWATURE AND TITLE OF CERTAIN	mo				29c. LICENSE NUI	WBER 2 19	29d. DATE SIGNEO (Month, Day, Year) MAY /7 /49			
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.		MAY 2 2 1995	your diwater in	hours.								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



1995

2. DATE OF DEATH MONTH MAY 18

18,

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Thomas

Leroy

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PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPINGE AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO MAINING TO TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO UNCERTAIN 1 YES 2 NO UNCERTAIN 1 YES 2 NO UNCERTAIN 1	0 # £	5	CAUSE (Disease or Injury	D	/00 AG A GOMESTANIA							
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NO NO THE STATE OF DEATH Netural 1	上 年 報 章	S	EXAMINER?	HOSPITAL:	26. PLACE OF D		one)					
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29e. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and pieca, end due to the cause(s) end manner as stated. 29e. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and pieca, end due to the cause(s) end manner as stated. 29e. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and pieca, end due to the cause(s) end manner as stated. 29e. CERTIFFIER (Check only one) 1 CERTIFFIER (Check only one) 2 DM DM DM DM DM DM DM DM DM DM DM DM DM	A the rath v	≥				M 1	YES 2 NO					
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THE STATE OF THE S	ATTE ATTE		4 Homicide detarmined					Only or	iown, State)			
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 445300 May 19, 1995 Mari Blackburn, M.D. 9512 Harford Road Baltimore MD 21234	DIR DIR	12	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, death occ	urred at the time.	date and piece, end	tue to the cause	(s) end menn	er en stated		
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 445300 May 19, 1995 Mari Blackburn, M.D. 9512 Harford Road Baltimore MD 21234	PITAL ERAL 72	₹	one) 2 MEDICAL EXAMINE	R: On the basis of a	ramination and/or investig	ation, in my opinie	on, death occured at	the time, date ar	nd place, and	dua to the	tause(s) and m	tenner se stated
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mari Blackburn, M.D. 9512 Harford Road Baltimore MD 21234	HOS Withi	8										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mari Blackburn, M.D. 9512 Harford Road Baltimore MD 21234	를 볼 볼	8	M DI MIS				# t .		1			, Day, Year)
Mari Blackburn, M.D. 9512 Harford Road Baltimore MD 21234	2 2 3	2	1. 1.0	1 2			1442	300		May	19,	1995
31. Date Filep (Month, Day, Year) 32. REGISTRAR'S SIGNATURE MAY 2 3 1995 Juli Windowski	1	, " <u> </u>										
MAY 2 3 1995 Julia Davidson (1)	10			, M.D.	9512 Hai	rford I	Road Ba	altimo	re, M	ID 21	234	
MITT & 3 1333 State William Control of	_ Ψ		31. DATE FILED (Month, Day, Year) M ΔΥ 9 9 1ΩΩΕ	32 REGISTRA	R'S SIGNATURE							
			כפבו פי וחייי	falla de	Moorbanket							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Jr.

Aydlett,

3. TIME OF DEATH

7:45

Approximata Interval Between

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should note:
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	cal examiner must be notified at once.

_	1 - STATE REGISTRAR	STATE OF MARYL	CERTIF	RTMENT OF ICATE OF		MENTAL HYG REG.						
	1. DECEDENT'S NAME (First, Middle, Last)	DOLORES MAE BE	- DELO		SNTON	2. DATE OF DEAT MONTH MAY	18 19	95 8	:16 p N			
	4. SOCIAL SECURITY NUMBER 215-28-0680	1 - M 2 X F	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTY (Month, Day, Ye MAR 28,	1931	B. BIRTHPLACE (State or Foreign Country) Maryland				
OR	9a. FACILITY NAME (If not institution, give s 11060 Rolan Park			96. CITY, TOWN	OR LOCATION OF D	EATH	-	ry of DEATH				
DIRECTOR	10a. STATE 10b. COUNT	,	10c. CI	TY, TOWN OR LOCA	ATION		10d, INS					
F	Maryland Some	rset			Chance		LIMITS?					
FUNERAL	11000 P 1	D 1		1	of, ZIP CODE 2182		10g. CITIZ	EN OF WHAT	COUNTRY?			
NE NE	11060 Rolan Park	USA	BACE - American Indian									
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wi								
TO BE COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind of	USUAL OCCUPAT	TION nost of working	16b. KIND O	BUSINESS/INDU					
	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Stock Stock		Clork	Morry 1	and Nati	1	D1-			
	12th Stock Transfer Clerk Maryland National Ba 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname)											
	"Unknown"	Streett RIC	HARD E. ST	TREETT		-"Unknow	MAE	ENGLAN	D			
	Shirley L. Plumme	er			and Number or Rural							
	26a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		PLACE AND DATE		Name of etery 05/	DATE 29/22/95	E, LOCATION — CI		State			
	21. SHGHATURE OF FUNERAL SERVICE LICE THE 22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A.											
	George E. MacNabb 301 Frederick Rd. Baltimore, MD 21228											
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory streat, shock, or heart failure. List only one ceuse on each line. Approximats interval Between Onset and Death disease or condition.											
	resulting in death) s											
Z	Samuelle He and the and the Computer Flust Failure MTHS											
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Nessea Parking Coulded Arykuttu											
正	that initiated events DIE TO (OR AS A CONSEQUENCE OF):											
CERT	resulting in death) LAST d. ASCUD YES											
CAL	PART II. Other significent condition	contributing to death b	ut not resulting	in the underlyin	ng ceuse given in	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDI	DID TODA CCO LICE CONT	VIDEO TO CALLED						10	YES 2 NO			
PHYSICIAN:	DID TOBACCO USE CONTI		F DEATH YI 26. PLACE OF DEA			ИП						
SICI	EXAMINER?	HOSPITAL:		OTHER:	me 5 Hasidence	6 Charles (Constitution						
BY PHY	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b, TIN	E OF 26c. IN	JURY AT	28d. OESCRIBE H		RED				
BY	1 Natural 5 Pending 2 Accident Investigation		1.55	M 1 🗆	YES 2 NO							
ETED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, tactory, offi	ce	261. LOCATION (SI City or Town, S	reet and Number or State)	Rural Route	Number,			
COMPLI		CIAN: To the best of my knowless. On the besis of examination							menner as stated,			
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1 lums			29c. LICENSE NUI	IBER 29d, DATE SIGNED (Month, Day, Year)						
10	DONALD WOOD LOCUST + QUINCY SALISBURY, MD 21801											
	31. DATE FILED (Month, Day, Year)	22. REDISTRAP'S SIGN	Bruns									

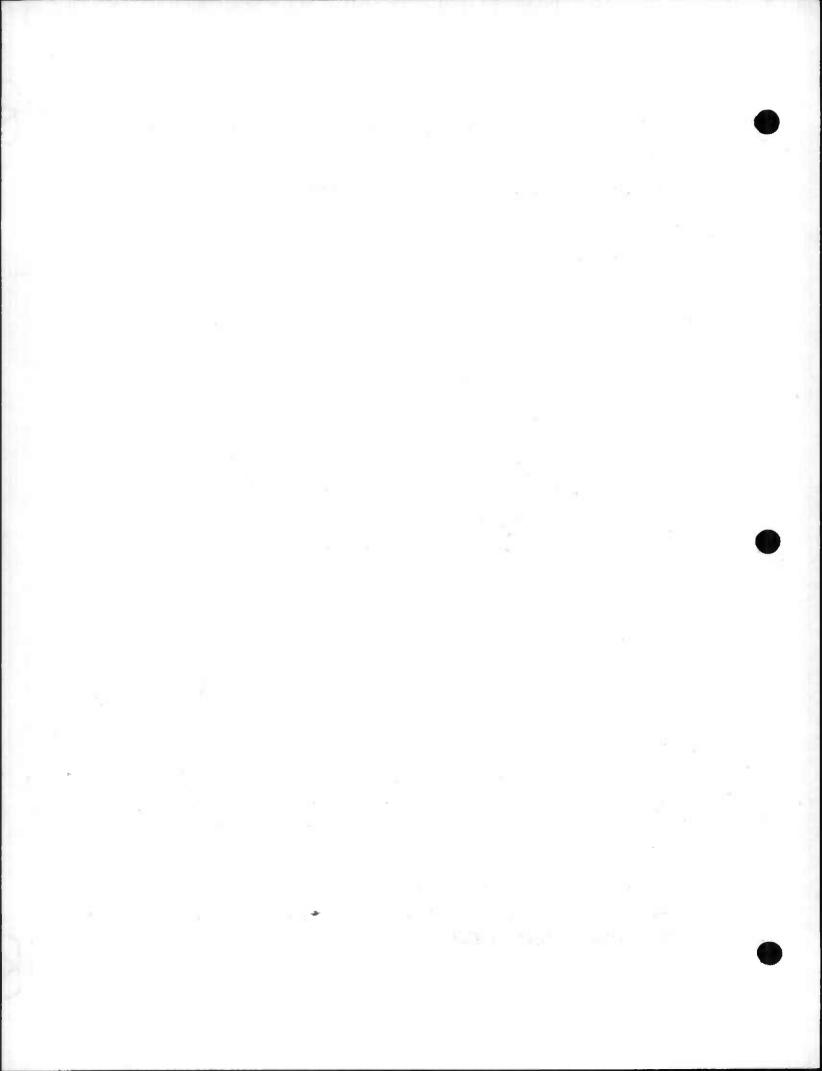
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If liem 28 is marked, or liem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
-			

	1 - STATE REGISTRAR	SIALE OF MA	CEF	RTIF	ICATE C	F DEATH	ואן טו	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)						2	DATE OF DEATH		YEAR	3. TIME OF DEATH		
	GREGORY 4. SOCIAL SECURITY NUMBER	RODERIO			BOOKI			MAY 19,	199	9 5 AR	10:45 A m		
	212-78-1122	5. SEX 8	B. AGE (In yrs. lest b	irthday) YRS.	MONTHS DA		N.	(Month, Day, Year)		Country			
	9a. FACILITY NAME (If not institution, give stre		37	rna.	OF CITY TO	VN OR LOCATION O		4-12-58			to., Md.		
H	UNIVERSITY S.T	,				IMORE	T DEAL	N	9c. COU	NTY OF DE	EATH		
C	RESIDENCE OF DECEDENT												
DIRECTOR	Maryland 10b. COUNTY		ľ		timore						10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER			Ва	TETWO	101. ZIP CODE			100 CITI	1 X YES 2 NO			
FUNERAL	3457 Vargas Cir	. Apt.	1-A 21244							SA			
Ü	11. MARITAL STATUS	12. WAS DECEDENT I		D	13. WAS	DECENDENT OF HIS	SPANIC	ORIGIN? (Specify Yes		14. RACE — American Indian, Black, White, atc.			
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAF				, apecify Cuban, Ma YES MIXNO S					y:		
	15. DECEDENT'S EDUCA	ATION	16a, DECE								ack		
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(G/ve	kind of a	vork done during se retired.)	most of working		16b. KIND OF BUS	SINE 33/ML	705 IHT			
MP	12			N	ONE								
00	17. FATNER'S NAME (Flist, Middle, Last) Robert H. Book			18. MOTHER'S NAME (First, Middle, Meiden Surname)									
BE	19a, INFORMANT'S NAME (Type/Print)	er						White					
2	Robert G. Book	er		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3457 Vargas Cir. Apt. 1-A Balto.									
	20m METHOD OF DISPOSITION		20b. PLACE AND	DATE	OF DISPOSITION	IName of	AL	DATE 200 LO	RATION -	City or Toy	Md. 21244		
	1 Surial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	/el from State	cometery, crema	IOI	nher place)		5	-24 Lan					
	21. SIONATURE OF FUNERAL SERVICE LICE	NSEE			22. NAM	AND ADDRESS OF	E CACH	ones Fu					
	Doub	Ca XO	-	_	46]	l Park	. O	eights	nera	IT H	ome		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between												
	anock, or near failure. List only one cause on each line.												
	disease or condition -> a. Dung force IMurity to Head and Porso												
_	DUE TO (OR AS A CONSEQUENCE OF):												
2	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
2	cause. Enter UNDERLYING CAUSE (Disease or injury												
CERTIFICATION	CAUSE (Disease or injury c. DUE TO (OR AS A CONSEQUENCE OF): resulting in desth) LAST												
8	d.												
CAL	PART II. Other algnificant conditions	contributing to de	eath but not read	ulting	n the underi	ying cause giver	in Pa	DEDECO	MED2		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă								1 YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?		
M	DID TOPACCO LISE CONTRI	DUITE TO CALL	CE OF DEATH	1 1/5		<u> </u>		_ ' `			1 YES 2 NO		
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUIE TO CAU			N (Check only o		AIN						
SIC		HOSPITAL:			OTHER:	fome 5 Residen	en a l	Other (Specific)					
PHYSICIAN: MED	27. MANNER OF DEATN	28a. DATE OF IN	IJURY 2	6b. TIM		INJURY AT WORK?	_	d. DESCRIBE NOW II	NJURY OCC	CUREP,	A / .		
BY	1 Natural 5 Pending 2 Accident Investigation	5/18/	95 /	23	Y M 1	YES 2 NO	5	sheet	assa	whe	dtbesters		
	3 Suicide 6 Could not be Nomicide determined	28e. FLACE OF a building, etc	INJURY — At home, c. (Specify)		treet, factory, o	ffice	26	H. LOCATION (Street a City or Town State)	nd Number	or Rural Ro	oute Number,		
91			0	`)	L	16-1	F- 17	gH3 Ave,		
COMPLETED	1 CERTIFYING PNYSICI 2 X MEDICAL EXAMINER:												
	199 SHOW THE AND TITLE OF CERTIFIER		Tenation and/or live	augano	n, in my opinio								
BE (1 DA	Wil.	MA			29c. LICENSE		n I.E.			(Month, Day, Year)		
٩	AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM 2	7) (Type,	Print)	1 0.	C . IV	1.E.	- Iv	IAY	19, 1995		
	-LARON LOCKE,	/W)	111 F	eni	n Stre	eet, Ba	lti	more, M	larv]	land	21201		
	MAV 9 9 1005	32. REGISTRARY	SIGNATURE										
_	MAY 2 3 1995 Juli	- hander M	most,					_					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within pure state death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OBATH MONTH DAY YEAR MONTH DAY YEAR												TIME OF DEATH		
	Wi	llie	Mae Bryan							May	19		1995 1		
	4. SOCIAL SECURITY NUMB 245-20-200) 2	5. SEX	6. AGE (In yrs. Is 70	yrs.	IF UNDE	DAYS	HOURS	MIN.	7. DATE OF B	8 Mars 19	24	N O L C	ACE (State or Foreign nCarolina	
OR	DEATON SE	PECIA		r) E				MORE	ION OF DE	EATH	N / A			тн	
DIRECTOR	MARYLAND	10b. COUNT				TIM		TION					od. INSIDE CITY LIMITS?		
FUNERAL	100. STREET AND NUMBER 2233N. FULT	ON A	VENUE		10f. ZIP CODE 2 1 2 1 7					10g. CITIZEN C				OF WHAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 3 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	2 TNO If yes, specify-Guban, Maxican					NIC ORIGIN? (Specify Yea or No— Black, Wi Specify:)):			- American Indian, Vhita, atc. BLACK		
COMPLETED	15. DEC (Specify only Elementary/Secondary (0	EDENT'S EDU y highest grad (-12)	JCATION e completed) College (1-4 or 5	Si	6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) IOUSEVIFF.					166. KIND OF BUSINESS/INDUSTRY $ec{N} \ / \ A$					
BE CON	WILLIE CO		D	Na.	18. MOTHER'S NAME (First, SMITHIE)							Sumame)			
TO B	194. INFORMANT'S NAME (Type/Print) ETHEL MAE JOHNSON 195. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2233 N. FULTON AVE BALTIMORE, MARYLA)										AND21217				
	20s_METHOD OF DISPOSITION 20s_METHOD OF DISPOSITION (Name of complete) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF DISPOSITION (Name of complete), cremetory or other place) 20s_PLACE AND DATE OF											, State			
	21. SIGNATURE OF FUNERAL SERVICE CICENSEE 22. NAME AND ADDRESS OF FACILITY											Z12 ZTHÄVENU			
CERTIFICATION	shock, or heart failure. List only one ceuse on each lins. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Renal Failure DUE TO (OR AS A CONSEQUENCE OF):													Interval Between Onset and Death	
MEDICAL	PART II. Other algorifica			t not resulting in the underlying cause given in						Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO			ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO		
IAN: N	25. WAS CASE REFERRED TO	O MEDICAL					26. P	LACE OF	DEATH (Ch	eck only one)					
PHYSICIAN:	25. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 VES 2 NO 28. DATE OF INJURY (Morph, Death 28. DATE OF INJURY (Morph, Death 1 Netural 5 Pending 1 V A Netural 5 Pending 28. DATE OF INJURY (Morph, Death 1 V Res 2 NO 28. DATE OF INJURY (Morph, Death 1 V A N 1 VES 2 NO N A N 1 VES 2 NO N A N 1 VES 2 NO N A N 1 VES 2 NO N A N 1 VES 2 NO N A N 1 VES 2 NO N A N N A														
ETED BY	3 Suicide 6	investigation Could not be datarmined	28e. PLACE C	OF INJURY — At h						281. LOCATION City or To	N (Street a wn, State)	N/A		te Number,	
COMPLE	one)		ER: On the basis of a											nd manner as stated.	
TO BE C	2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Morith, Day, Year) 5/19/95														
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Thomas Folkemer 4231 Postal C.+. Pasadena Mary lawel														
	31. DATE FILED (Month, Day, Year) MAY 2 3 1995 Subsidiar Reveals														

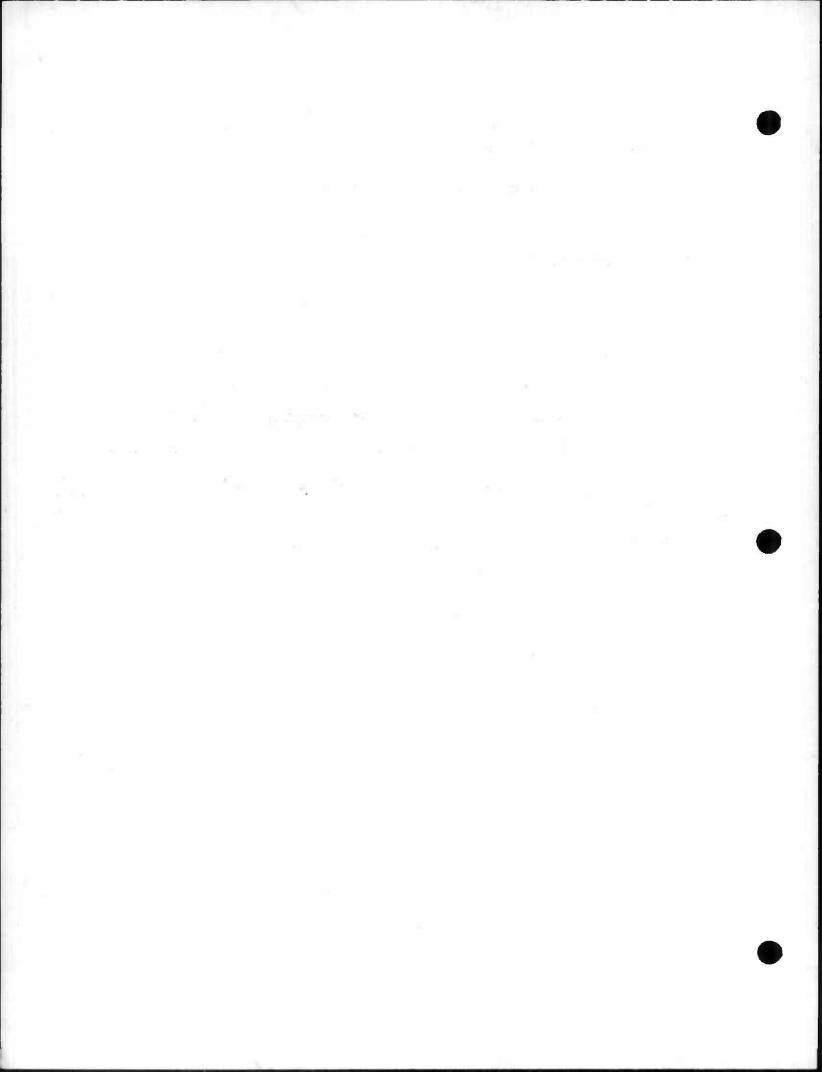
C. Thomas Folkemer 42 1 Losted Cit. A sadora Marylawa

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIF	TOATE	JF DEATH	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last) IDA BRAUN	NSTEIN			2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATH				
		AGE (in yrs. lest birthday)	T INDER AND		MAY 19,1			12:53 P M				
	104-20-8364 1 M 2 💢 F	94 yrs.	MONTHS DA	SAR IF UNDER 24 HRS. WS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC. 25,		Country	PLACE (State or Foreign)				
_	9e. FACILITY NAME (If not institution, give street and number)		96. CITY, TO	WN OR LOCATION OF D		9c. COUN						
DIRECTOR	5900 PARK HEIGHTS AVE., A	APT.#301	BAL	TIMORE			N/A					
H.	10e. STATE 10b. COUNTY	10c. CF1	Y, TOWN OR L	OCATION				10d. INSIDE CITY LIMITS?				
	MARYLAND N/A		BALTIM	ORE				1 X YES 2 NO				
FUNERAL	10e. STREET AND NUMBER			101. ZIP CODE			NAT COUNTRY?					
Ä	5900 PARK HEIGHTS AVE., A			21215		S.A.						
5	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1	EVER IN U.S. ARMED YES 2 NO R OR DATES	DECENDENT OF NISPA s, specify Cuben, Maxic	- American Indian, White, etc.								
ВУ	3 X Widowed 4 Diverced IF YES, GIVE WAR	R OR DATES		YES 2 X NO Speci			Specify					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT'S		PATION og most of working	16b. KIND OF BUS							
9	Elementary/Secondary (0-12) College (1-4 or 5+)	Ille. Do NOT u	se retired.)									
MP	12	SEAMS	TRESS		C	LOTHI	NG					
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Sumarne) DAVID KATIZ MIDIAM DIVACE											
BE	DAVID KATZ MIRIAM DIVACK 19e. INFORMANT'S NAME (Type/Print) 19b. MAIL INO ADDRESS (Street and Number Co. Burg. Stock Auguste City of Number Co. Co. Co. Town Stock Auguste City of Number Co. Co. Co. Town Stock Auguste City of Number Co. Co. Co. Town Stock Auguste City of Number Co. Co. Co. Town Stock Auguste City of Number Co. Co. Co. Town Stock Auguste City of Number Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.											
2	The state of the s											
	MRS. DOROTHY FARKAS 3902 LUMO RD, RANDALLSTOWN, MD. 21133											
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)	cemetery, crematory or o	other plece)	N (Name of	1							
	4 Donation 5 Other (Specify) 11. BIGNATURE OF FUNERAL SERVICE LICENSES 12. NAME AND ADDRESS OF FACILITY 13. DONATION OF FUNERAL SERVICE LICENSES 14. Donation 5 Other (Specify) 15. DONATION OF FUNERAL SERVICE LICENSES 15. DONATION OF FUNERAL SERVICE LICENSES 16. DONATION OF FUNERAL SERVICE LICENSES 17. DONATION OF FUNERAL SERVICE LICENSES 17. DONATION OF FUNERAL SERVICE LICENSES 18. DONATION OF FUNERAL SERVICE LICENSES 19. DONATION OF F											
	Indue L Stille	er an	SO	L LEVINSON	& BROS.,I		M	21215				
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart failure. List only one cause on each line.											
- 4	IMMEDIATE CAUSE (Finel Onset and Death											
i	disease or condition reaulting in death) a. Acute Wyocucus my unturn DUE TO (OR AS A CONSEQUENCE OF):											
z		-		V								
을 I	n any, rauding to immediate	R AS A CONSEQUENCE O	F):									
2	cause. Enter UNDERLYING CAUSE (Disease or Injury											
CERTIFICATION	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): rasulting in death) LAST											
H H	ď.											
	PART II. Other algnificant conditions contributing to de	eeth but not reaulting	in the under	lying ceuse given in	Part I. 24s. WAS AN			WERE AUTOPSY FINDINGS				
EDICAL					PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE				
ME				/				OF DEATH?				
Z	DID TOBACCO USE CONTRIBUTE TO CAU	SE OF DEATH YI	ES NO	UNCERTAL	N 🗆							
¥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEA		one)								
YSI	HOSPITAL:	R/Outpetlent 3 🗆 DOA	OTHER:	Home 5 Residence	6 Other (Specify)							
PHYSICIAN:	27. MANNER OF DEATN 1 Matural 5 Pending 28e. DATE OF IN. (Month, Dey.		JURY	INJURY AT WORK?	28d. DESCRIBE NOW II	NJURY OCCL	JRED					
B	2 Accident investigation	NJURY — At home, farm,		YES 2 NO								
COMPLETED	3 Suicide 6 Could not be determined	c. (Specify)	street, ractory,	office	281. LOCATION (Street e City or Town, State)	nd Number o	or Hurai Ro	ute Number,				
٦	29e. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my	knowledge, death occurr	ed at the time.	date and place, and due	to the cause(a) and man	nor on eleter	a					
NO.	one) 2 MEDICAL EXAMINER: On the beele of exam							and manner as stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIER			29c, LICENSE NU								
1. (Attend Masses 1227												
유	38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE				1		1	, /)				
	Robert m. Cooper mo	100 NB	roadn	icy Balt	une mo	21	23	,				
	MAY 2 3 1995 July Judger	SAIGNATURE						1				
- 1												



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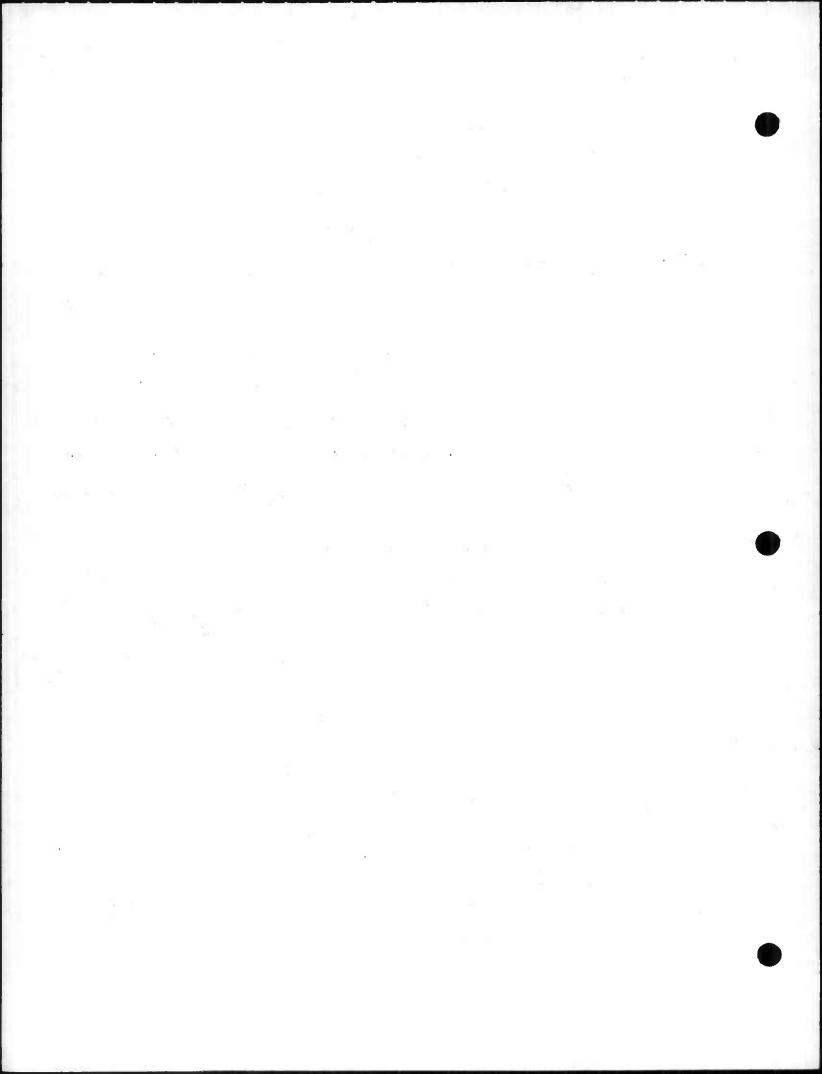
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR CE			DEATH	REG. NO							
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH			3. TIME OF DEATH				
	FREDA ISRAEL BROWN				MAY 18	, 199	YEAR 95	10:00Pm				
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last	birthday) II	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		e. BIRTH	PLACE (State or Foreign				
	218-32-3751 1 M 2 M F 85	YRS.	NTHS DAYS	HOURS MIN.	OCT. 9,1		Country	RYLAND				
	9e. FACILITY NAME (If not institution, give street and number)	91	. CITY, TOWN	OR LOCATION OF D		9c. COUN						
OR	1190 W. NORTHERN PARKWAY, APT.#9	907		IMORE		N/A						
DIRECTOR	RESIDENCE OF DECEDENT											
H	10e. STATE 10b. COUNTY		OWN OR LOC			10d. INSIDE CITY LIMITS?						
	MARYLAND N/A	BAL	TIMOR	₹				1 X YES 2 NO				
₹.	10e. STREET AND NUMBER		1	01. ZIP CODE		10g. CITIZ	EN OF W	HAT COUNTRY?				
FUNERAL	1190 W. NORTHERN PARKWAY, APT. #90			21210			S.A.					
5	11. MARITAL STATUS 1 Never Merried 2 Married FORCES? 1 YES 2 TAN	MED O	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Years, Puerto Rican, atc.)	14. RACE Black	- American Indian, White, atc.					
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES TO	1 TES 2 NO Specify:						WHITE				
	15. DECEDENT'S EDUCATION 16e. DEC	CEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY										
E	(Specify only highest grade completed) (Gh	ve kind of work Do NOT use re	done during a	nost of working	160. KIND OF BU							
4		OPRIET	Y)P			V						
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)	JI KILLI	OIC	18. MOTHER'S NA	ME (First, Middle, Melden	ROCER	<u> </u>					
	DAVID LIPSITZ											
BE		MAILINO AD	DRESS (Street	GERTRUDE FLAKS RESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)								
임								,MD. 21210				
	20s, METHOD OF DISPOSITION 20b. PLACE A	NDDATEOFO	ISPOSITION (Varne of	DATE 20c. LO	CATION - C						
	1 A Burlet 2 Cremation 3 Removal from State cometery, crem	EMIJNA	Place) H-ATT	CHATM C	ONG. 21/95	BAL.	TTMC	RE,MD.				
- 1	21. SIGNATURE OF FUNERAL SERVICE LIGENSEE		22, NAME	AND ADDRESS OF FA	CILITY		11110	ACH / FID.				
- 1	· (but / Mar 7 1 .				& BROS.,I							
\neg	23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, Approximate interval Retween											
	anock, or near tanore. Car only one ceuse on each line.	50	enter the m	oue or dying, ade	n as ceroiac or reap	iratury arre	at,	Interval Between Onset and Death				
	II IMMEDIATE CAUSE (Fine)											
ŀ	disease or condition resulting in death) a. Estable - Ocala June Due to (or as a consequence of): Dult to (or as a consequence of):											
_	DUE TO (OR AS A CONSEQUENCE OF):											
흔	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
3												
E												
CERTIFICATION	resulting in death) LAST											
	PART II. Other algnificant conditions contributing to death but not re	sulting in t	he underlyk	an cause alven in	Part I. 24s. WAS AN	ALITORAY	1					
DICAL		aditing in t	ne underlyn	rg cause given in	PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
					1 YES 2	₽ NO		OF DEATH?				
ME	DID TORACCO LISE CONTRIBUTE TO CALICE OF DEAT	THE VEC		-			1	T YES 2 NO				
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT 25. WAS CASE REFERRED TO MEDICAL 26. PLACE		Check only one		4 L L							
딣	EXAMINER? HOSPITAL:	0	THER:									
PHYSICIAN:	1 ☐ YES 2 ☐ NO ☐ 1 ☐ Inpettent 2 ☐ ER/Outpettent 3 ☐ 27. MANNER OF DEATH ☐ 28e. DATE OF INJURY	26b. TIME O		me 5 Residence	6 Other (Specify) 26d. DESCRIBE HOW II	N HIPPY OGGI	IDED					
	1 Natural 5 Pending (Month, Day, Year)	INJURY	W	ORK? YES 2 NO	200. DESCRIBE NOW II	NJUNT OCCE	MED					
BY	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At hom	ne, ferm, stree			28f. LOCATION (Street of	and Number o	r Burni Dr	nute Alumbae				
COMPLETED	4 Homicide datermined building, atc. (Specify)		,		City or Town, State)	ina rvaniour o	rigrar Fic	ALL HUMBON.				
۳	290. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge deep			50.55								
Ž	(Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dest	rn occurred a	t the time, dat	e end place, end due	10 the cause(e) end mer	iner ee stated	l.					
ပ္ပ	290 SIGNATURE AND TITLE OF CERTIFIER		i my opinion,			d due to the	ceuse(e)	end manner as stated.				
H H	ASSOCIATION AND THE ENTERNANCE OF CERTIFIER			29c. LICENSE NUN	IBER	29d. DATE	SIGNED	Month, Oby, Year)				
၉	30. NAME AND ADDRESS OF ERSON WHO COMPLETED CAUSE OF DEATH (ITEM	070 /T	-11	100		,	5/	118				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAPSE OF DEATH (ITEM	. (Type, Prin	000	OW CT	ad Bd	6.4	10	2129				
	MAY 2 3 1995	6				,						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the man after death. Face 6 may be retained by the hospital or attending physician and completely filled in by the function page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68769



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DIVISION OF VITAL RECORDS, P.O. BOX 6876

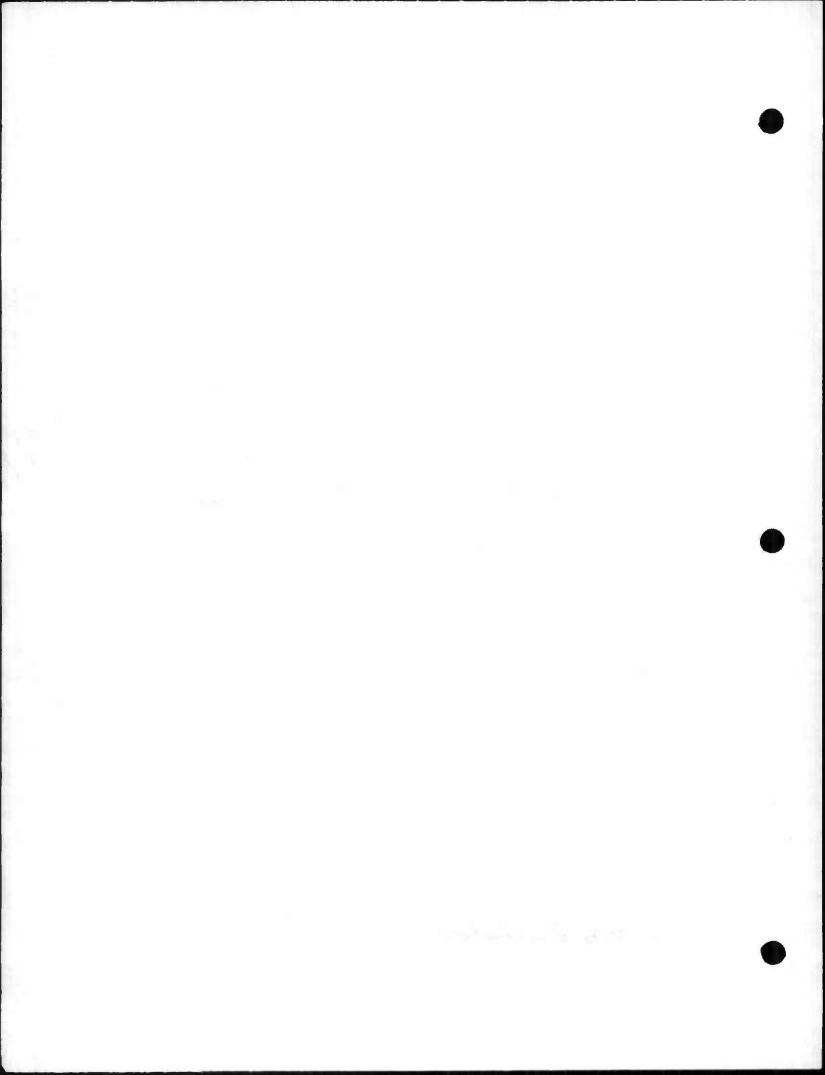
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH Boone Idridae 10:30 A M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 4/13/10 5. SEX 6. AGE (In yrs. last birthday IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign 705-12-3769 85 DAYS HOURS 1 M 2 | F YRS Calvert County 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 509 Mount Holly Street DIRECTOR Baltimore, Maryland Balto. City RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY MD Baltimore, City Baltimore 1 K YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 509 Mount Holly Street 21229 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR DR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 ND Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married BY Specify: 3 Widowed 4 Divorced World War 1 Black COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 8+) Retired Rail Road 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Howard Boone notified at Eleanora Wallace 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ethel C. Boone 509 Mount Holly Street Balto. MD 21229 Pe 20a_METHOD OF DISPOSITION
1 □ Burlal 2 □ Cremation 3 □ Removal from State
4 □ Donation 8 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Owings Mill MD arrison Forest Vet. Cem \$1/23/d5 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Estep Bros. Funeral Home P.A. 1300 Entaw Place Ralto medicai 23. PART . Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ Myocardial Infarction
DUE TO (DR AS A CONSEDUENCE OF): resulting in death) event, Coronary Disease traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO Hypertension any COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: R 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER 1 YES 2 ND 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated, 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D35363 119 45 2

10 N. Greene Street Baltimore

BVAMC



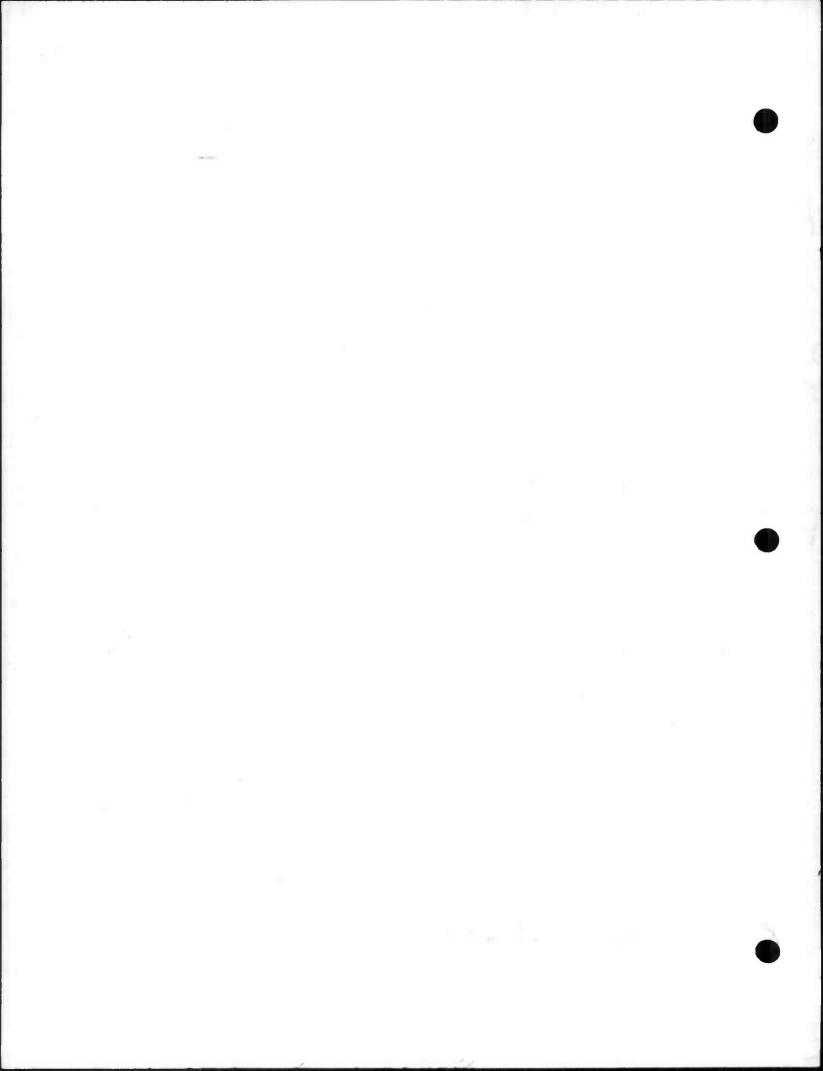
ITEM: 7. PER INFORMANT FILM G-724 6/30/95 t.t

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health Hugher prior prior removal, removal after the market or than 28 is market or than 23 shows any interval or other transmatteness the market or than 28 is market or than 23 shows any interval or other transmatteness. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND /	DEPARTMENT (OF HEALTH AN	MENTAL	HYGIE
C	EDTIELCATE	OF DEATH		

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	DAWN NICC	DLE BROY	WN			MAY 15	. 199	5 0959 Am
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In		F UNDER 1 YEAR	IF UNDER 24 HRS.			BIRTHPLACE (State or Foreign
	214-15-2665	¹□ ** 2√2√ 17	YRS.	ONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, 22 Year) May 27, 1	977 Wa	ashington D.
	9s. FACILITY NAME (If not institution, give s	treet and number)	9	b. CITY, TOWN (OR LOCATION OF D		9c. COUNTY	
DIRECTOR	PHYSICIANS MEM	ORIAL HOSP	ITAL	LA PI	ATA		СНА	RLES
12	10a. STATE 10b. COUNTY	4	10c. CITY,	TOWN OR LOCAT	TION			10d. INSIDE CITY
	Maryland Cha	rles	Br	yans l	Road			1X YES 2 NO
4	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
7 🗓	2794 Marshall	Hall Road			20616		U.S	5.A
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	or No- 14.	RACE — American Indian,
ВУ	DONever Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 NO Speci	an, Puerto Rican, etc.) fy:		Black, White, atc. Specify:
				1				Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)		k done during mo	ON st of working	16b. KIND OF BU	SINESS/INDUST	RY
19	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r	•				
MP	12	0 [Stude	nt		Cante	rbury	School
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
BE	Gregory	Brown			Luwa	n Thomps	on	
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	DRESS (Street a	nd Number or Flural	Route Number, City or Tow	n, Stata, Zip Cod	le)
-	Luwan Brown		2794 M	arshal	ll Hall	Rd, Brya:	ns Rd	Maryland
	20s_METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Rame 4 Donation 5 Other (Specify)	oval from State 20b. F	PLACE AND DATE OF	DISPOSITION /Na	me of	/19/95 C	CATION - City	or Town, State
	21. SIGNATURE OF FUNERAL PERVICE LIC			Y	ID ADDRESS OF FA			
	7116	1				_		
	Horsel C	les		Adams	s Funer	al Home,	Aquaso	o MD 20608
	23. PART I. Enter the diseases, prospective. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. MULTIPLE	ch line.	UKI ES	ae or aying, suc	en as cerdiec or reap	ratory arreat,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с	CONSEQUENCE OF):					
AL C	PART II. Other algolficent condition	a contributing to death bu	t not resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN	AUTOPSV	24b. WERE AUTOPSY FINDINGS
MEDICA						PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
								1 YES 2 NO
Z	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES		UNCERTAI	N 🗆		1
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE DF DEATH	Check only one)				
\S	XXVES 2 \(\text{NO} \)	1 Inpatient 2 X ER/Outpat			e 5 🗆 Residence	6 Other (Specify)		
표	27. MANNER OF DEATH	28e. DATE OF INJURY (Mpnth, Day, Year)	28b, TIME C	F 28c. INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D
BY	1 Netural 5 Pending 2 Accident Investigation	5/15/95	0939	AM 1 U		DRHUBR OF	AUTO V.	STRUCK IMPAC
ED E	3 Suicide 6 Could not be	28s. PLACE OF INJURY - building, atc. (Specif)	Al home, ferm, atre	et, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Ru	ural Route Number,
2	4 Homicide determined	- and the topology	SIEARI			RT 223 W	SLRORF	MARYUMID
COMPLET		CIAN: To the best of my knowled				to the cause(a) and mar		
8	7	0.0		y opinion, o			a ann to the car	use(s) and manner es stated.
TO BE	296 SIGNATIONE AND TITLE OF CONTIFIEN	Zallet	N		O.C.M.			16,1995
	MARIO 7 GU	COMPLETED CAUSE OF DEAT			t, Bali	timore, M	aryla	nd 21201
	MAY 2 3 1995	R. REDISTRAR SEIGHAT	URE					



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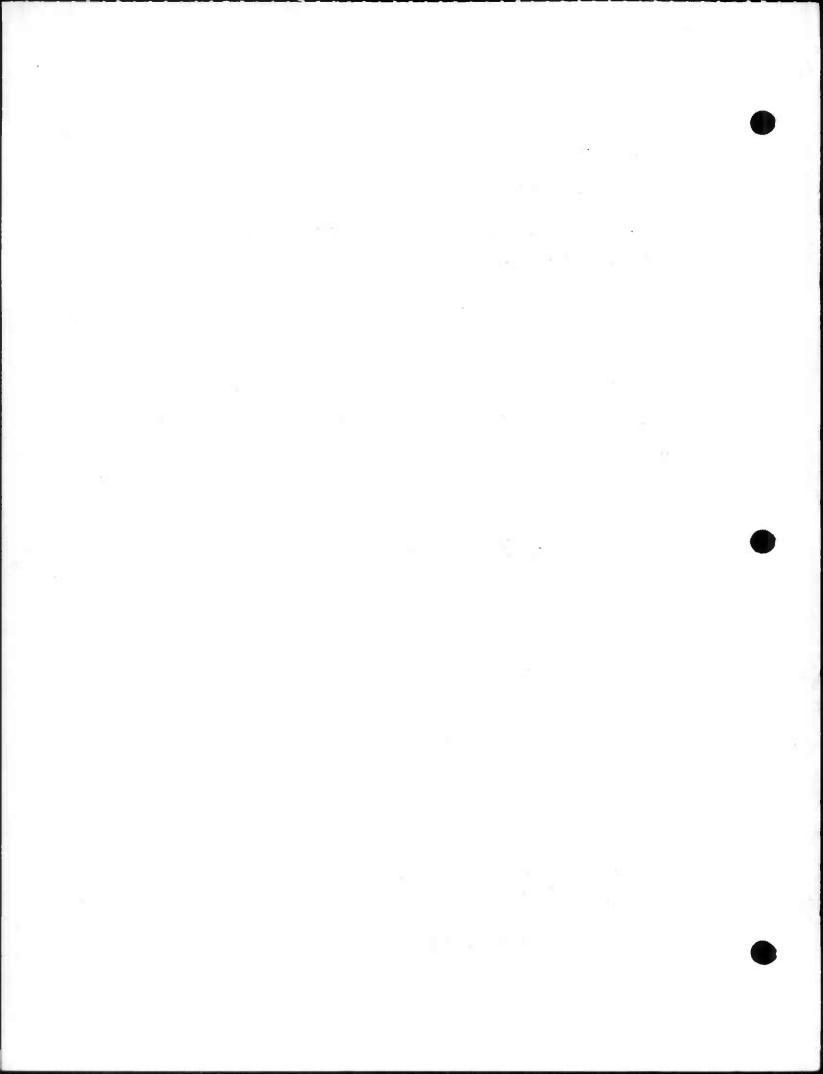
1. DECEDENT'S NAME (First, Middle, Last) DATE OF DEATH 1342 SAMUEL C. BELT A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. . DATE OF BIRTH a. BIRTAPLACE (State or Foreign 213-12-0999 tXXII 2 ☐ F 73 HOURS YRS. 10-25-21 BALTIMORE 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH SAINT JOSEPHS MEDICAL CENTER Pages 1, 2, 3 s DIRECTOR TOWSON BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10d. INSIDE CITY LIMITS? 1 YES AND 10c CITY TOWN OR LOCATION MARYLAND BALTIMORE RODGERS FORGE permit. 10e STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 112 DUMBARTON ROAD (APT.D) 21212 as the burial-transit U.S.A. attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 NO 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, Whita, alc. 1 Never Married XX Married If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES X NO Specify: IF YES, GIVE WAR OR DATES BΥ Specify: 3 Widowed 4 Divorced WORLD WAR WHITE ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use relied.) 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high hospital or 10 Elementary/Secondary (0-12) College (1-4 or 5+) HOME IMPROVEMENTS CONTRACTOR COMPL 2 YEARS funeral director, page 5 should be detached once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) retained by the RUFUS VERNON 70 BELT ELIZABETH LORRAINE HOLDEN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) No. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212
112 DUMBARTON RD., BALTIMORE, MARYLAND 2 MARY M. BELT (WIFE) 9 20s. METHOD OF DISPOSITION

| No. | Buriel | 2 | Cremetion | 3 | Removal from State Раде 6 глау 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Must 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEMETERY 5-22 GARRISON FOREST, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212 wo attending physician and completely filled in by the after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart fallure. List on one cause on each line Interval Between 5 Opset and Death IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) event. bunial, traumatic CERTIFICATION Sequentially list conditions. to DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ag prior cause. Enter UNDERLYING ATTENDING PHYSICIAN: The law requires that the death certificate CAUSE (Disease or Injury other signed by the attending ph Health and Mental Hygiene that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? T YES 2 NO shows 1 TES 2 NO peen 10 has be Dept. 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN XX PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. BLACE OF DEATH (Check only one) certificate h NO TES 2 NO HOSPITAL OTHER: ☐ Impatient 23☐ DCIA 4 | Nursing Home 5 | Residence 6 | Other (Specify) the or 27. MANNER DE DEATH 28s. DATE OF INJURY (Month, Day, Year) 35c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c is marked, 1 Satural 1 YES Z NO BY After 1 I Accident 3 🗌 Swickle 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d litem 28 is 6 Could not be determined COMPLETED 4 - Homicide OR 29s. CERTIFIER t CERTIFIAND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL I within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated 296. SIGNATURE AND FITLE OF CERTIFIER 29d. DATE SIGNED (Mosth, Day, Year) BE 2 PERSON WHO CO 10+1 31. DATE FILED (Month, Day, Year MAY 2 3 1995

STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE

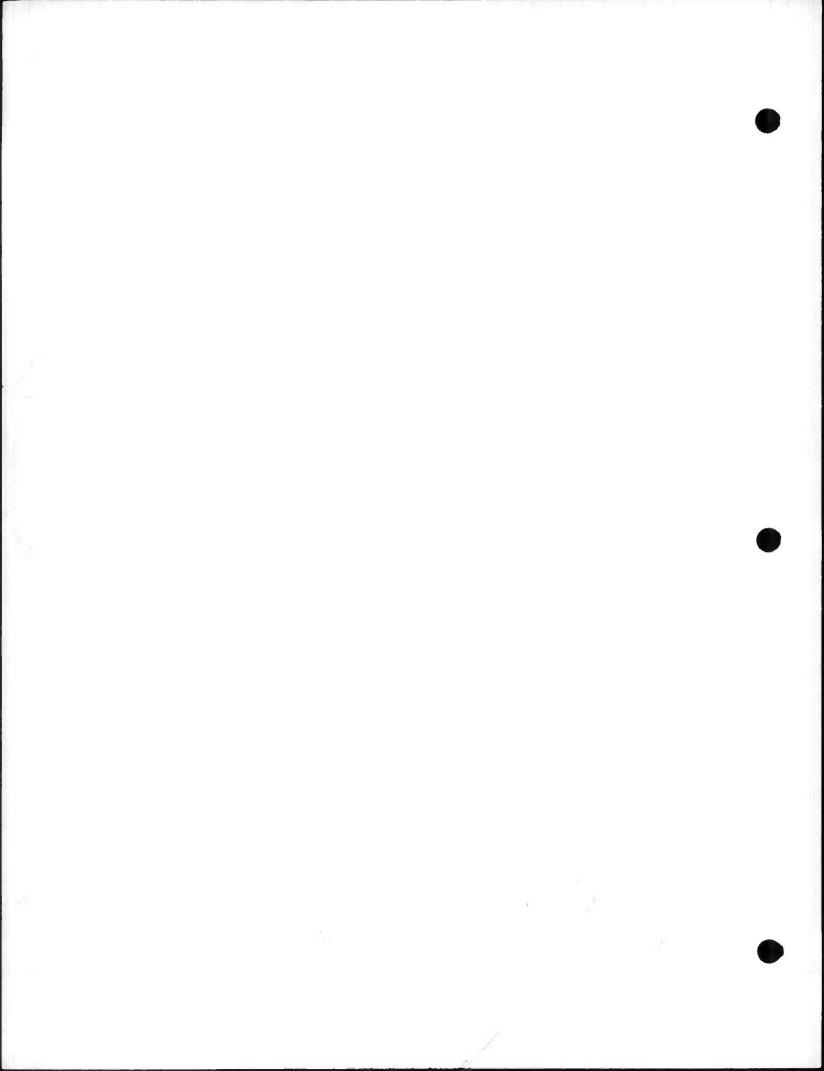
CERTIFICATE OF DEATH



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

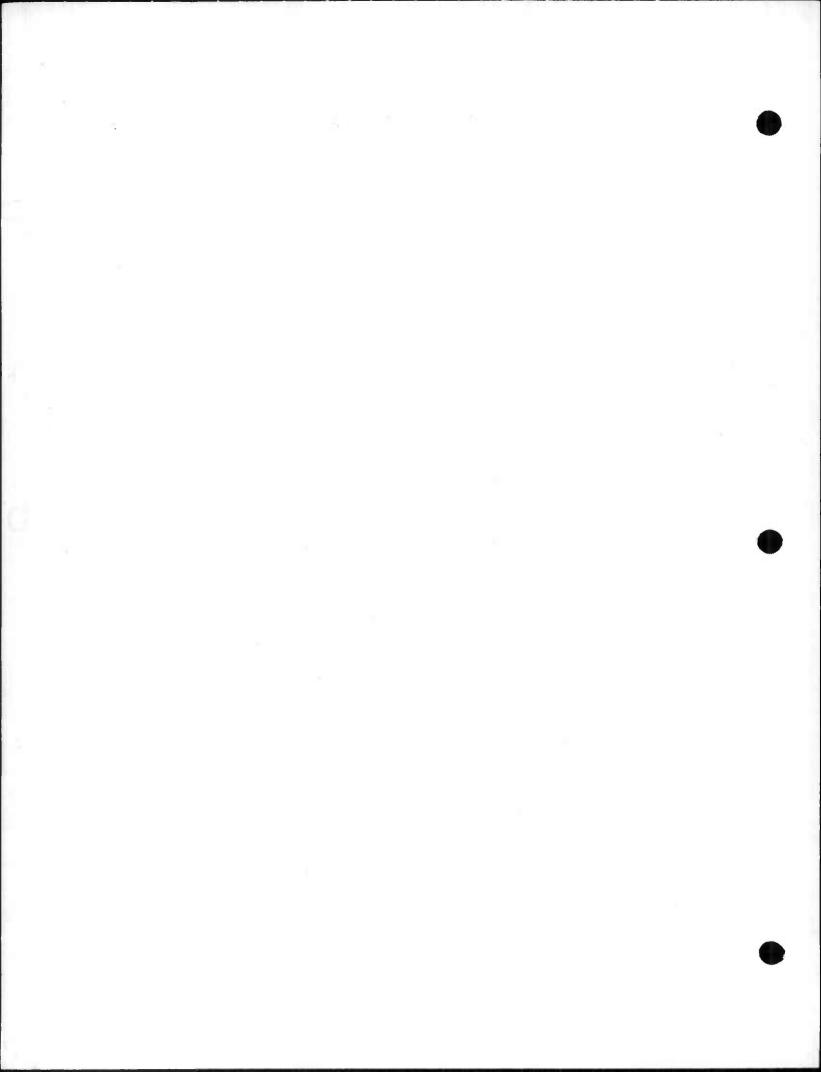
		1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH		MEAG	3. TIME OF DEATH
		Paul BARR									Маи		199		0245 AM
		4. SOCIAL SECURITY NUME 217-24-8290		5. SEX	6. AGE (in yrs	67 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	7. DATE OF I	y, Ybar)	0.7	8. BIRTH Countr	PLACE (State or Foreign y) Jersey
pjno		9a. FACILITY NAME (If not in				O / THS.	9h. CITY	TOWN	OR LOCATION	ON OF DE	Octobe	er 4,		NEW NTY OF D	
3 should	E C				i+ a 0							- 1	9c. COU	NTY OF D	EATH
2, 2,	стов	POCTORS RESIDENCE OF DEC			WAAX.				am, A	Saryl	and				
P.00	DIRE		Drings	r e Georges			ry, town o owie	OR LOCA	TION						10d. INSIDE CITY LIMITS?
THE STATE OF THE S		10e. STREET AND NUMBER		Georges	<u> </u>	Ь	owie	10	f. ZIP CODI	E			to- OT	TEN OF Y	1 YES 2 NO
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UZO physician. burial-transit permit. Pages	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (S	pecify Yea	or No-	14. RACE	— American Indian,
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be ne	F	William Bar				15 Re	dfiel	.d C	t., I	Balt	imore,	MD 2	21236	5	
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death. Page tuneral direct.	ļ	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE Rona	ld Wade	, Dir					Sta YTUR				
the death. Page 6 m the funeral director, oval.		Marke	M	Ma	w										21201
hours after of in by the or removal	1		eart tellure.	complications the List only one cau	it caused tha use on each I	death. Do Ine.	not anter	the mo	de of dyl	ing, such	as cerdiec	or reapin	atory arr	reat,	Approximata Interval Between
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requires that signed of Health any	MEC												_ 110		OF DEATH?
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PHY star and and and and and and and and and and	BY PI	1 Natural 5	Pending Investigation	(Month, D	Pay, Year)	194	JURY M	1 🗆 '	PRK7 YES 2	NO	28d. DESCRIE	BE HOW IN	JURY OCC	CURED	
CTOR: A after d	8		Could not be determined	26a. PLACE O building,	of INJURY — At etc. (Specify)	home, farm,	street, facto	ory, offic			26t. LOCATIO City or To	N (Street an wn, State)	nd Number	or Rural R	oute Number,
	COMPLET	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge,	death occur	ed at the ti	me, data	and placa,	and due	to the cause(a	and mann	ner as stat	ed.	
HOSPITAL FUNERAL WITHIN 72 TANT: IL	OM														and manner as stated.
To the Hospit To the Funer De fied within 7	B	296. SIGNATURE AND TITLE	OF CERTIFIER	BIT	Affend	m	thijs. N	Cim	29c. LICE	NSE NUM	BER 3		29d. DATI	SIGNED	(Month, Day, Year)
F F 3 ₹	2	30. NAME AND ADDRESS OF		COMPLETED CAUS	SE OF DEATH (I	TEM 27) (Type	, Print)			- 2			-	,	5-95 MD 20715 Bowie
		David F		etcher	-, m.s	0, 1	4300	2 (F-4/1	ant	Fox	Les,	, #	15	Bowie ?
_		31. DATE FILED (Month, Day,		· ·	R'S SIGNATURE					"				-	
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			Ayres		oun Sr		2. DATE OF DEATH		3. TIME OF DEATH 195 11:55 A M
200		4. BOCIAL SECURITY NUMBER 214-26-6423	5. SEX 8. AGE (In 1 M 2 D F 65	yrs. last birthday) YRS.	MONTHS DAY		7. DATE OF BIRTH (Morth, Day, Year) April 22,		BIRTHPLACE (State or Foreign Country) Maryland
, 3 should	DR.	9a. FACILITY NAME (If not institution, give Medbridge Nurs				n or Location of D		9c. COUNTY	y of DEATH Utimore
s 1, 2,	رظ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT		Day of					
nit. Page	DIRECTOR	Maryland N/A	Y		v, town on Lo Utimor				10d. INSIDE CITY LIMITS? 1 YES 2 NO
ınsit pem	FUNERAL	100. STREET AND NUMBER 3441 Kenyon Avenu	ue			21213		U.S.	N OF WHAT COUNTRY?
funeral director, page 5 should be detached for use as the burial-transit permit. Pages xaminer must be notified at once.	BY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 X NO	If yes,	DECENDENT OF HISPA specify Cuben, Maxic (ES 2 NO Speci	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy:	s or No — 14	Black, White, etc. Specify: White
or use as	ETED	15. DECEDENT'S EDU (Specify only highest gradi Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of v life. Do NOT us	vork done during	ATION most of working	16b. KIND OF BU	SINESS/INDUS	
thed ft	COMPL	8th grade	College (I-C or 5+)	Carpen	ter		Long S	Shorem	an
detach once.	ő	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden		
ed De	BE	Manley Calhoun 190, INFORMANT'S NAME (TYPO/Print)	-			Cora W			
5 should notified	5	Ella Calhoun (Wi	60)				Aouto Number, City or Tow Baltimore,		21213
ector, page must be		20g. METHOD OF DISPOSITION 1 A Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	20b. P	LACE AND DATE OF	F DISPOSITION	(Name of	DATE 20c. LO	CATION — City	y or Town, State e, Maryland
al dire		21. SIGNATURE OF FUNERAL BERVICE LI		ociavo o a			rail Home	Millord	e, margrana
e = e		Matth	Olyan	8	3331	Brehms L	ane, Balti	more,	Md. 21213
completely filled in by the ial, cremation, or removal event, the medical		23. PART I. Enter the diseases, or shock, or heart feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse on eec a. DUE TO (OR AS A D	the deeth. Do not the fire.	alu	mode of dying, aud	th as cerdiec or reap	ratory arread	t, Approximate Interval Between Onset and Desth
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the attending physician Mental Hygiene prior b njury, or other traur	CERTIFICATION	CAUSE (Disesse or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	7:	9004			1048
d by the att and Menta ny injury,	CAL C	PART II. Other algnificant condition	ns contributing to death but	not resulting I	n the underly	ring cause given in			24b. WERE AUTOPSY FINDINGS
been signed by it. of Health and shows any in	MEDIC						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
as been Dept. of 23 sho		DID TOBACCO USE CONT					N 🗆		1 TYES 2 NO
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the the	PHYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outpati	28b. TIMI	E OF 28c.	ome 5 Assidence	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCUE	RED
er this th with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		WORK? YES 2 NO			
CTOR: After this cost after death with 1	ETED B	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, stc. (Specify,	At home, farm, a	treat, factory, of	ffice	281. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,
FUNERAL DIRECTOR: After this certificate has been signed within 72 hours after death with the State Dept. of Health ITANT: If Item 28 is marked, or Item 23 shows an	COMPLE		ICIAN: To the best of my knowled						ause(a) and manner as stated.
TO THE FUNER be filed within IMPORTANT:	O BE C	286. BIGHATURE AND TITLE OF CERTIFIE	10			29c. LICENSE NUI	52	> 5	IGNED (Month, Day, Year)
_	F	Dr. S. SRINIVAS.	5601 LOCHE	H (ITEM 27) (Type.	Print) B L	D BA	LTIMORE	M	D21239
2		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI	URE			-		



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FOR STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR WILLE CARMICHAE 9:41 am May 20 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday 5. SEX IF UNDER 1 YEAR B. BIFTHPLACE (State or Foreign 1 M 2 - F DAYS HOURS Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Medical Center Baltimore Towson, Maryland 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MORE регтіт. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBE 101, ZIP CODE use as the burial-transit death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ZHO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: RACE — American Indian, Black, White, atc. 1 Never Married 2 Married ВY 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Е Elementary/Secondary (0-12) Por College (1-4 or 5+) ABORER COMPL page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) notified at UNK. 8 19a. IMFORMANT'S NAME (Type/Print) 2 99 20a METNOD OF DISPOSITION
1 M Burlal 2 Cremation 3 4 Donation 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of the medical examiner must n/3 □ Rer funeral director, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE the 23. PART IL Ener the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory filled in by or heart feliure. List only one ceuse on each line Interval Betwe 0 IMMEDIATE CAUSE (Final Onset and Death cremation. disease or condition and completely fit burial, cremation HEART FALLIRE HOURS other traumatic event. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE YEARS CERTIFICATION Sequentielly list conditions. prior to DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST been signed by the attending it. of Health and Mental Hygier shows any injury, or PART ii. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: 1 - YES 2 - 10 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? this c 28d, DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO After 1 BY 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) If Item 28 Is COMPLETED 6 Could not be DIRECTOR: / 4 Nomicide 29a. CERTIFIER best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. FUNERAL (within 72 h estigation, in my opinion, death occured at the time, date and place, and dua to the cause(a) and manner as stated. TO THE H TO THE F be filed v E AND TITLE OF CES 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 20 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT K. BRAWLEY SUITE 304 THE PROFESSIONAL CENTER, 120 SISTER PIERRE DRIVE MAY 23 STATEGIS LAVE AS SON' TANK

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		1 - FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF I		MENTAL HYGI			
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		David Frederic	k Clayton				May 18	199	9:00 A	L
,		4. SOCIAL SECURITY NUMBER 217-62-4863	5. SEX 8. AGE (III	yrs. last birthday) YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea 3-19-195		BIRTHPLACE (State or Foreign Country) Md.	n
3 should	~	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNT	Y OF DEATH	
2,	Į į	3813 North Poin	t Blvd.					Bal	timore	
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	v ltimore		3altimor				10d. INSIDE CITY LIMITS? 1 YES 2 [X] NO	
-55	ERAL	100. STREET AND NUMBER 1835 DEVERON ROAD	d		10	1. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 (2) YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DEC	CENDENT OF HISPA	NIC ORIGIN? (Specify an, Puerto Rican, etc. fy:	Yes or No- 1	4. RACE — American Indian, Black, White, atc. Specify.	
	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION Completed) College (1-4 or 5+)		,		-51110010	BUSINESS/INDU		_
MARYLAND 21 retained by the hospital or 5 should be detached for u	at once.	17. FATHER'S NAME (First, Middle, Last)	74	owne	<u>. </u>		AME (First, Middle, Ma			17
MARYL retained by 5 should be	B 8	William D. Clayto	in Jr.	19b. MAILING	AODRESS (Street	Jean and Number or Rural	Burgenei Proute Number, City or		(ode)	_
IORE, e 6 may be ector, page	8	Regina Clayton		1835	Deveron	Road Ba	ltimore,	Md. 212	34	
	must	1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)			of disposition (N wher place) CTULCE (Corp. 5/		OWSON,		
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hir c4 hours tely filled in nation, or re	event, the medical	IMMEDIATE CAUSE (Final	List only one ceuse on ea	ch line.					Interval Batwe	eati
O. BOX 68. ing physician and conging physician and conging to burian and congress of the traumatic	r other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	DUE TO (OR AS A ODUE TO (ODUE TO (OR AS A ODUE TO (ODUE T			peth	7 477	wur	Fau men	ti
DS, P. the death of the attend	S S	DATE II On a stantil and a stantil	d							_
equires that the signed by of Health and hows any I	S 3	PART II. Other aignificent condition	a contributing to death bu	t not resulting	in the underlyin	g cause given in	PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
		DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH Y	S NO [UNCERTAI	N 🗆			
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SICIAN: The certificate In the State I, or Item	14S	1 YES 2 NO	1 Inpatient 2 ER/Outpa 28a, DATE OF INJURY	tient 3 DOA	4 Nursing Home 5 Rasidence 6 Other (Sp.					
NG PHYS ter this ath with	marked BY PI	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)		URY WO			28d. DESCRIBE HOW INJURY OCCURED		
	ED S	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, etc. (Specif	— At home, farm,	street, factory, offic		28f. LOCATION (Str. City or Town, St	et and Number or late)	Rural Route Number,	
AL DIR.	ANT: If Item 2 COMPLET		CIAN: To the beat of my knowle							_
THE HOSPITAL THE FUNERAL filed within 72	C	29b. SIGNAY SHE AND THE E CERTIFIES		and or mive any and	an, an my opinion, c	29c. LICENSE NU			GGNED (Morm, Day, Year)	J.
TO THE HOSPIT TO THE FUNER De filed within 7	TO BE	autil	(Jus)			D2	3829	1 5	14195	
15	F	30. NAME AND ADDRESS OF PERSON WH								-
1		Dr. Albert Del	oskey 515 Fai	rmont A	ve. Suit	e 330				

Dr. Albert Deloskey 515 Fairmont Ave. Suite 330

MAY 23 1995

AND THE CONTRACTOR ML

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

ITEM: 18. PER F.H. FILM G-723 5/23/95 t.t UNK 95-126

TREGISTRAM CERTIFICATE OF DEATH 1. DECEDENT NAME (FIRST MAKE (FIRST MAKE) ALL ADDRESS AND AL
TATALAND 4. ASOCIAL SECURITY NUMBER 1. S. SEX 1. S. SEX 1. ASOCIAL SECURITY NUMBER 1. S. SEX 1. ASOCIAL SECURITY NUMBER 1. S. SEX 1. ASOCIAL SECURITY NUMBER 1. S. SEX 1. S. SEX 1. ASOCIAL SECURITY NUMBER 1. S. SEX 1. S. S
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Sequentially list conditions Due to (or as a consequence of): Total tributes Due to (or as a consequence of): To
196. INFORMANT'S NAME (TypesPrint) 196. INFORMANT'S NAME (TypesPrint) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Steins, Zip Code) 12002 AMBLEWOOD DR., LAUREL, MD., 20708 206. METHOD OF DISPOSITION 1
20a, METHOD OF DISPOSITION 20b, PLACE AND DATE 20b, PLACE AN
1 Redurate 2 Ceremation 3 Removal from State Connection, cerematory or other place) ST SCEM 5-20-95 SHERIDAN NEW YORK
23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death)
23. PART I. Enter the disease, or complications that ceused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, pr heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): 1 Yes 2 No 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 Yes 2 No
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Anock, or heart fellure. List only one cause on each line. Interval Between Oneet and Death MMEDIATE CAUSE (Final disease or condition reaulting in death) Due To (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury this initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1 YES 2 NO
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OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 Input lent 2 ER/Outpattent 3 DOA 4 Nursing Home 5 Residence 6 Vinher (Specific) AT COUNTY.
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W 4 Homicide detarmined
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as stated.
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
O C M F MAY 14 1995

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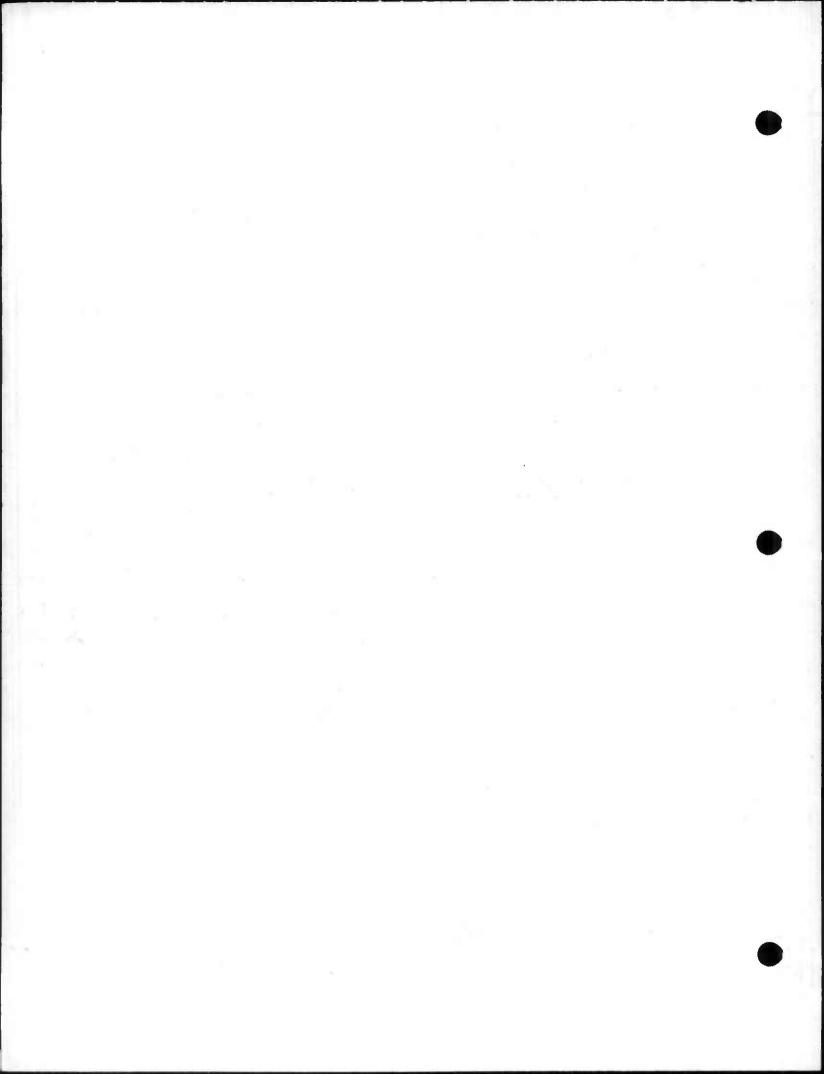
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CE	HILL	AIE U	F DEATH	1	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH												
	MARY HELEN CHRISTMAS						May 18	4:30 p M					
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest		UNDER 1 YEAR		_	7. DATE OF BIRTH		995 a. BIRTI	IPLACE (State or Foreign		
	212-32-4851	1 🗆 M 2 🔀 F	88	YRS. MOH	NTHS DAYS	HOURS N	MIN.	NOV. 16 19	206	Count	YLAND		
	9a. FACILITY NAME (If not institution,	give street and number)		9h	CITY, TOW	OR LOCATION				INTY OF C			
E				30.			J. DEAL						
5	801 Winters La	ane Apt. 441			IN	/A			BA	-IIM	DRE CO.		
DIRECTOR	10s. STATE 10b. CO			10c. CITY, TO	OWN OR LOC	ATION			-		10d, INSIDE CITY		
E C	HARYLAND	BALTIMORE CO.				N/A					LIMITS?		
	10e. STREET AND NUMBER			IN/A			1 TYES 2 X NO						
FUNERAL	and the second second	No. Ant 444		111. 411 45341				10g. CITIZEN OF WHAT COUNTRY?					
ᄬ	801 Winters La			21228				U.S.A.					
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV	TER IN U.S. ARM	ED)	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Vill yes, specify Cuben, Maxican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.				
BY	3 Widowed 4 Divorced	FORCES? 1 T	OR DATES		1 🗆 YI	ES 2XXNO	Specify:		Specify:				
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ا ب	Elementary/Secondary (0-12)	College (1-4 or 5+)	We. E	Do NOT use ret	tired.)								
COMPLETED	11th grade		D	DOMESTIC				N/A	1				
8	17. FATHER'S NAME (First, Middle, Last	·				'S NAME	(First, Middle, Maiden S						
BE (James Russell V	Velling				Nel1	ie F	E. Butcher	•				
	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILINO AOC	ORESS (Stree			ite Number, City or Town		p Code)			
2	Juanita A. Spend	cer	R+	. 1 Bo	ox 204	Ann	oma i	ttox. Va.	24!	522			
	20a, METHOD OF DISPOSITION						Jinu				nuro. State		
XYBuriel 2 Cremation 3 Removal from State													
WESTERN STAR CEMETERY 5/22 CATONSVILLE, MAR 21. SIGNATURE OF PUREBAL SERVICE LIBERTY WILLIAM C. BROWN COMMUNITY F/H										PIAKTLANU			
										F/H			
	- ///(LROWN							14.1.6	. / 11			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	shock, or heart fellure. List only one cause on each line.												
	IMMEDIATE CAUSE (Final disease or condition												
	resulting in death)												
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8	Sequentially list conditions, and a construction of the conditions of Sulfar Making Cyang												
CERTIFICATION	oue to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING												
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Ė	that initiated eventa resulting in death) LAST	OUE TO (OR	AS A CONSEOU	IENCE OF):		1.10	, í	1 .	5	1	0		
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						/		_ /			1 - YES 2 - NO		
z I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
HYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
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유	4 Homicide 6 Could not detarmine	Duliding, atc.	(Specify)	-, raini, acidat	, rectory, orr		2	8f. LOCATION (Street ar City or Town, State)	rd NUMBE	or Hunal F	noune Number,		
4		HYSICIAN: To the best of my l											
COMPLET	One) 2 MERICAL EXAM	MINER: On the basis of examin	nation and/or Im	reatigation, in	my opinion,	death occured a	nt the tim	ne, data and place, and	due to ti	ne cause(s) and manner as atated.		
U L	296. SIGNATUME AND TITLE OF CERT			,		29c, LICENSE					(Month, Day, Year)		
∞		0/1/1		sh.	ila. I	02	a	7/1	D	Siding	20/95		
2 ∦	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	OEATH OTH	27) (Type Print	vera	1/2	-1	F4/	_	7/	19/1.		
	1 1 - 10	. 10	11		5	16 N	4	0 11	n	1	2 11		
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	MAY 2 3 1995"	ALL ALLEGETRAR	TUBE					0	(
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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	bled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s, or removal.	medical examiner must be notified at once.	TO BE COMPLETED BY ELIMEDAL DIDECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	TMEN ICAT	T OF H	IEALTH DEAT	AND I	MENTA	L HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATN 3, TH				OEATN		
	REBECCA CHIRUMBOLE								MONT	y 19,™		YEAR	4	30 PM		
	4. SOCIAL SECURITY NUMBER	5. SEX	5. SEX 6. AGE (In yrs. lest bird			R 1 YEAR	IF UNDER		7. DATE	OF BIRTN		8. BIRTNE	PLACE (State	or Foreign		
NC.	216-01-2338 1 D M 2 DXF			3 YRS.	MONTHS	DAYS	HOURS	MIN.		h, Day, Year) Y 24,1	911	L Country) L MARYLAND				
	9a. FACILITY NAME (If not institution, give a			9b. CIT	Y, TOWN C	OR LOCATIO	ON OF OR		1 2-1/1		NTY OF OE		.VD			
	HEBREW HOME OF G	R	OCKV	ILLE				MOI	NTGOM	TERY						
5	RESIDENCE OF DECEDENT															
DIRECTOR	10a. STATE 10b. COUNT	OR LOCAT	OR LOCATION 10d, INSIDE CI													
	MARYLAND MONTGOMERY N. POTOMAC										1 YES	2 NO				
FUNERAL	100. STREET AND NUMBER 14009 NATIA MANOR DRIVE 20878										10g. CITIZEN OF WHA					
NE							208	/8				U.S.	Α.			
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEDEN FORCES? 1	T EVER IN U.S. AF	RMED NO	13.	WAS DEC	ENOENT O	F NISPAN	VIC ORIOII	OIN? (Specify Yes or No— 14. RACE — American, stc.) 14. RACE — American Black, White, at			- American	Indien,		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE V	AR OR DATES				2 NO						WHI	re		
	15. OECEDENT'S EOU	CATION	100 00	ECEDENTIS	HOULE	000000							- 4			
E	(Specify only highest grade completed) (Give kind of work done during most of work							g	16b. KIND OF BUSINESS/INDUSTRY							
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	"	HOUSE						ľA	' HOMI	Ε				
MO	17. FATHER'S NAME (First, Middle, Last)						18 MOTA	IED'C NA	ME /Elmt	Middle, Maiden						
ŏ	SAMUEL	HOFFMAN					10. 11011		RA		ISHE	2				
BE	19a. INFORMANT'S NAME (Type/Print)		19	h MAILING	ADDRES	e (Street e	nd Number									
2	196. INFORMANT'S NAME (Type/Print) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11901 TARRAGON RD., REISTERSTOWN, MD. 21136									5						
	20a. METNOD OF DISPOSITION															
	1 Surial 2 Cramation 3 Removal from State Camelory Cramatory or other places															
	4 Donetton 8 Other (Specify) OHEB SHALOM MEMORIAL PARK 5/21/95 REISTERSTOWN, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE															
	SOL LEVINSON								1 & B	ROS.,I	NC.					
	6010 REISTERSTOWN RD., BALTO., MD. 21215									L5						
	23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one ceuse on each line. Approximate interval Between															
	Interval 50															
	disease or condition											ODAK				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) ■ ACUTE RENAL FAILURE OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): Onset and Deat 10 DAY ONE TO (OR AS A CONSEQUENCE OF): INSULIN DEPENDENT DIABETES MELLITUS YEAR: DUE TO (OR AS A CONSEQUENCE OF):													11		
N	Sequentially list conditions,	ATHER	305C/E	ROT	10	C	ERE	BR	AL	11	IFAI	RC/	11	nonth		
ERTIFICATION	if any, leading to immediate	DUE TO	(OR AS A CONSE	QUENCE O	F):		-	7	0	-1	10.0			1=001		
5	CAUSE (Disease or injury that initiated exercises.) LASULIN DEPENDENT DIABETES MELLITUS YEARS DUE TO (OR AS A CONSEQUENCE OF):										EARS					
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST															
ä	d															
	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS															
5	ASPIRATION PNEUMONIA								PERFOR			AVAILABLE P COMPLETION				
빌											OF DEATH?	Notice				
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN										710					
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)															
Sic	EXAMINER? HOSPITAL: OTHER:															
Ŧ	27. MANNER OF DEATH	28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT						Y AT 28d. DESCRIBE NOW INJURY OCCURED								
ВУР	1 Naturel 5 Pending (Month, Day, Year) INJURY 2 Accident Investigation					WORK?										
DB	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, fectory, office 28f. LC							28f. LOC	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
Ш								City								
COMPLET	29s. CERTIFIER (Check only (Check only) (Certifying PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
MF	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.															
- 11																
H	290. DATE SIGNED (MONTH, Day, 1981)									-						
2	of were	you		111			DI	05	88	2	- m	IAY	17,	1995		

DOW MD D

1 CAUSE OF DEATH (ITEM 27) (Type, Print)

W 6/2/ MONTROSE Road, ROCKVILLE TEVEN

31. DATE FILED (Month, Day, Year)
MAY 2 3 1995

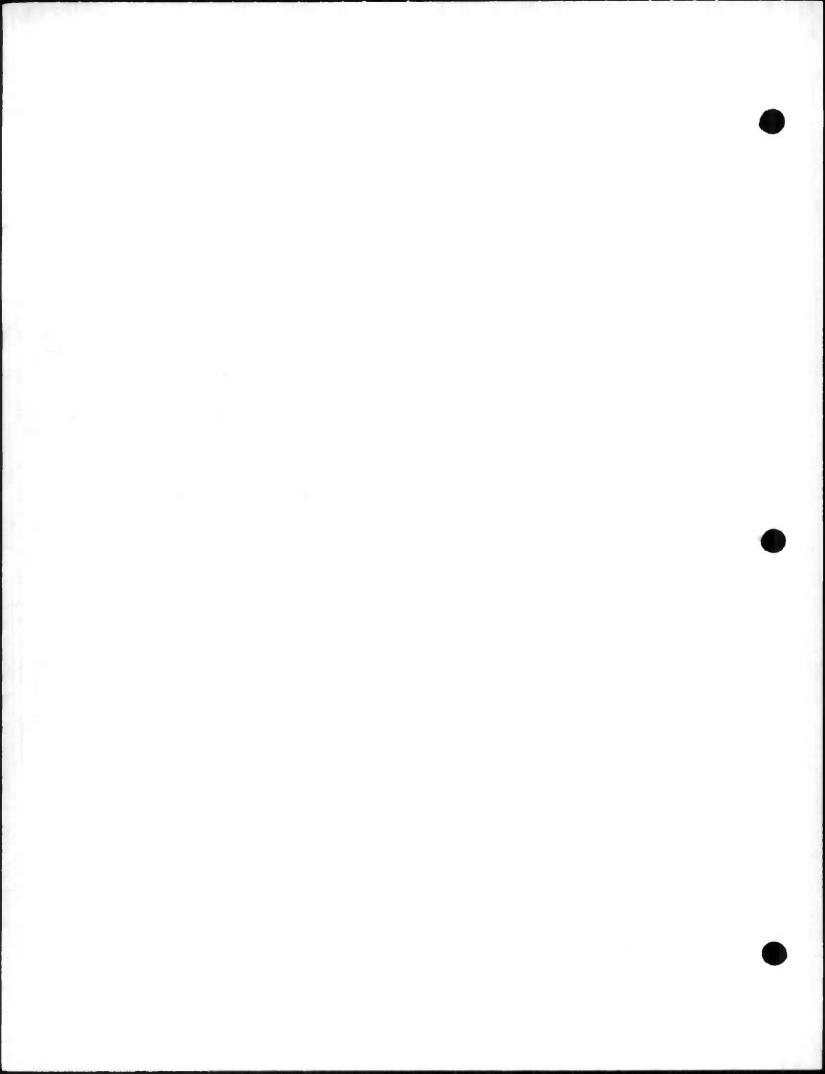
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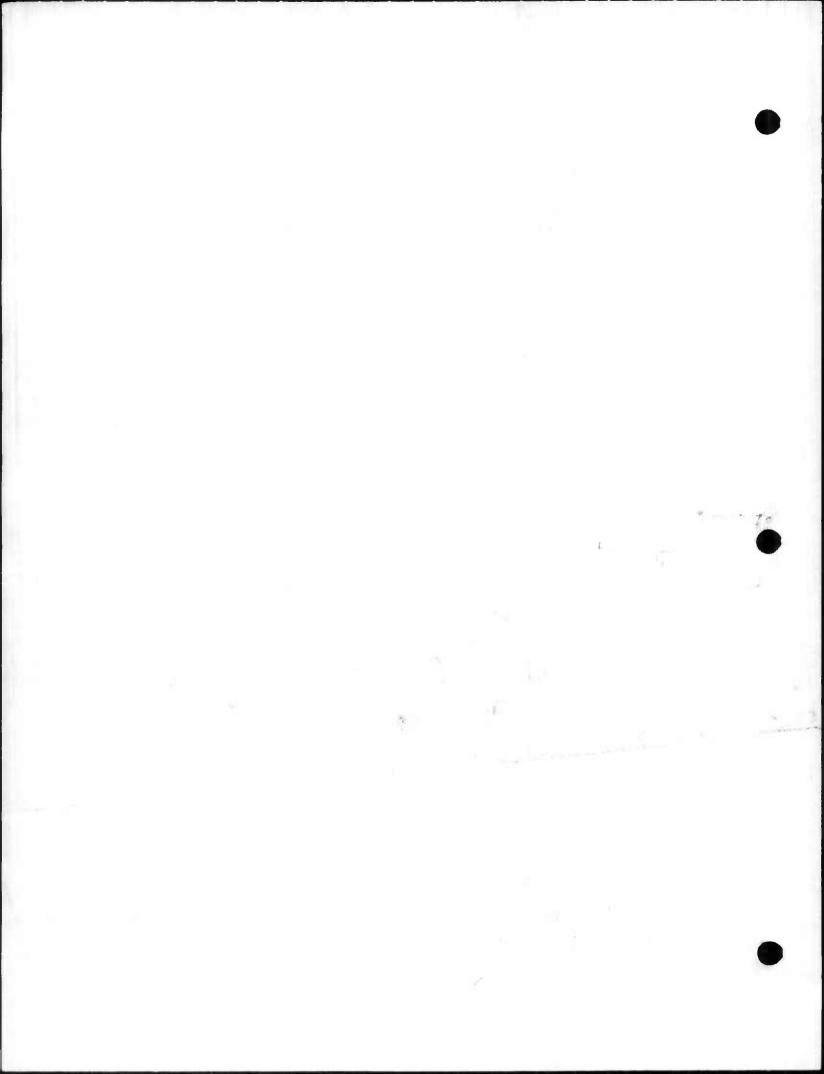
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlat, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.
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Pages 1, 2, 3 should

	1 - FOR STATE REGISTRAR	STATE OF MARYI			HEALTH AND I	MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA	RUTH	COL	EMAN		2. DATE OF DEATH MONTH MAY 21	, 1995	3. TIME OF DEATH 1:05P M
	4. SOCIAL SECURITY NUMBER 217-50-5972	1 □ M 3/3/F	(In yrs. last birthday) 48 vns.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) 1-12-47	8. BIF	TTHPLACE (State or Foreign untry)
POP	9a. FACILITY NAME (if not institution, give: 1824 E. 28TH				TIMORE		9c. COUNTY OF	
DIRECTOR	10a. STATE 10b. COUNT MD N/			Y, TOWN OR LO	EXTION RECITY			10d. INSIDE CITY UMITS? 14 Aves 2 \(\text{NO} \) NO
FUNERAL	100. STREET AND NUMBER 1824 E. 28TH	ST.			101. ZIP CODE 212	18	U.S.A	F WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes,		HC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	or No- 14, RA	ACE — American Indian, ack, White, atc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION completed) College (1-4 or 5 +) N/A	16a. DECEDENT'S (Give kind of vite. Do NOT us MAIL &	work done during se retired.)	most of working	16b. KIND OF BUS	EINESS/INDUSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) JAMES	WEST	TIALD &	TIDE (ME (First, Middle, Maiden		
TO B	19a. INFORMANT'S NAME (Type/Print) WALTER COLEMAN	, JR.	19b. MAILING 1824			Fourte Number, City or Town		MD. 21218
	20a. METHOD OF DISPOSITION 1 \$\frac{1}{2}\text{Buriat} 2 \text{Cremation} 3 \text{Rem} 4 \text{Donation} 5 \text{Other} (Specify)	ovel from State CO	netery, cremetory or of RBUTUS	ther place)	Name of AL PARK	5/25	CATION — City of	
	21. SIGNATURE OF FUNERAL SERVICE LA	DININI	ortie:	22. NAME	AND ADDRESS OF FAC	BETTS	FUNERA	AL HOOME 0,MD21213
	23. PART I. Enter the disease or shock, or heart feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Complications that cause List only one cause on a a. Revul	ach line.	ot enter the n	node of dying, suci	as cardiac or reapli	retory arrest,	Approximate interval Between
CERTIFICATION	MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
AL CE	PART II. Other algnificant condition	a contributing to death t	out not resulting i	n the underly	ng cause given in	Part I. 24s. WAS AN		4b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDIC						PERFORM		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
HAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT			1 🖸		
HYSIC	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	petient 3 DOA		ome 5 Residence	6 Other (Specify)	me !	tospice
B≺	1 Natural 5 Pending Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Spe	— At home, ferm, a	M 1	YES 2 NO	281. LOCATION (Street as		I Route Number,
COMPLETED	4 Nomicide detarmined	CIAN: To the best of my know		d at the time de	to and place and disc	City or Town, State)		
COMF		R: On the basis of examination			death occured at the	time, data and place, and	f due to the cause	
TO BE	30. NAME AND ADDRESS OF PERSON WH	nd Me	ATH (ITEM 27) (Type,	Print)	DZ6	923	▶ 5/	22/45
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	INAS U	M.	709 E	· LOMB.	ARD	ST.
	MAY 2 3 1995	Julia a kuden	Redett					DNMN-18 Rev 1/89



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218-74-6302 Image: 41 Yes Section Sectio										12:10 P
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MD N/A BALTIMORE CITY No. STREET AND NOMBER 13.24 N. AISQUITH ST 13.24 N. AISQUITH S	2, 3	СТОЕ	THE JOHNS HOPKINS HOSPIT	AL	В	ALTIMO	RE CITY		N/A	
1	Pages	DIRE								10d. INSIDE CITY
The state of the s				1		101.		0.1		WHAT COUNTRY?
The state of the s	cian. Il-trans	UNE	11. MARITAL STATUS 12. WAS DECE	DENT EVER IN U.S. A	RMED	13. WAS DEC				
12 N/A UNEMPLOYED N/A III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL III. PATHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. RATINGER STAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MANUSCHICA COMMON CONTROL ON THE FROM MAGIS CONTROL ON THE	ing physic		1 Never Married 2 Married FORCES?	1 YES 2 X	NO	if yes, spe	cify Cuban, Maxical	n, Puerto Rican, etc.)	Blac	k, Whita, etc.
12 N/A UNEMPLOYED N/A III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL III. PATHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. RATINGER STAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MOTHER'S NAME (FYSI, MAGIS, LAST) EARL W. HILL SELVERA COSBY III. MANUSCHICA COMMON CONTROL ON THE FROM MAGIS CONTROL ON THE	215 atten	Œ	15. DECEDENT'S EDUCATION (Specify only highest grade completed)					16b. KIND OF BUS		
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The grade of the control of the cont	5 5 5 E			cemetery, cri	ematory or other p	ece)	VQT	5/22 TAN	MEDOWNE	MD
The grade of the control of the cont	th. Pag eral di		.// 1///		,	22. NAME AN	D ADDRESS OF FAC	BETTS F	FUNERAL	HOME
INMEDIATE CAUSE (Final disease or condition resulting in death) BOURTO (OR AS A CONSEQUENCE OF): CAUSE (Final disease or condition resulting in death) BOURTO (OR AS A CONSEQUENCE OF): CAUSE (Final disease or condition resulting in death) BOURTO (OR AS A CONSEQUENCE OF): CAUSE (Final disease or condition resulting in death) BOURTO (OR AS A CONSEQUENCE OF): CAUSE (Disease or condition resulting in death) CAUSE (Disease	BAI ter dea the fur waf.		grange com	arle		1129	N. CAR	OLINE ST.	 BALTO 	,MD 21213
Sequentially liat conditions, if any, leading to immediate conditions and process of process of injury of the state of the	within 24 pletely fille cremation, ent, the		iMMEDIATE CAUSE (Final disease or condition resulting in death)	cute re	nal fa	ilure		n aa cardiac or reapir	atory arreat,	Approximata Interval Between Onset and Deat
PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PROGRESSIVE WULL CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBACCO USE OF DEATH YES NO UNCERTAIN 1 YES 2 NO DID TOBAC	P.O. BOX 68: h certificate be execute anding physician and co Hygiene prior to buria or other traumatic	SERTIFICATION	that initiated events	TYPTOCOC TO TO BE AS A CONSE ETTO LIVE TO JOR AS A CONSE	COLLECTION OF STATE O	uarrh ndvo	ne			6 month
26. PLACE OF DEATH TES NO UNCERTAIN XS 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. DATE OF INJURY 1 YES 2 NO 28. DATE OF INJURY 1 Notural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 28. PLACE OF INJURY At home, larm, street, factory, office 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. PLACE OF INJURY AT HOME, Day, Year) 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. PLACE OF INJURY AT HOME, larm, street, factory, office 28. PLACE OF INJURY AT HOME, Day, Year) 28. PLACE OF INJURY AT HOME, larm, street, factory, office 28. PLACE OF INJURY AT HOME, Day, Year) 28. PLACE OF INJURY AT HOME, Day, Year) 28. PLACE OF INJURY AT HOME, Day, Year) 28. PLACE OF INJURY AT HOME, Day, Year) 29. LICENSE NUMBER 290. SIGNATURE ON TITLE OF CERTIFIER 290. SIGNATURE ON TITLE OF CERTIFIER 290. DATE SIGNED (Month, Day, Year) 290. DATE SIGNED (Month, Day, Year) 290. DATE SIGNED (Month, Day, Year) 290. DATE SIGNED (Month, Day, Year) 290. DATE SIGNED (Month, Day, Year) 290. DATE SIGNED (Month, Day, Year)	y and the N		Por one in well to be a	12.1.	1 - 1 - 1	1	cause given in i	PERFORM	MED?	N. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
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29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. SIGNATURE for CERTIFIER 20b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	Re with O	- 1	27. MANNER OF DEATN 28a. DATE (Mont	OF INJURY	28b. TIME OF	28c. INJU WOF	RY AT		JURY OCCURED	
29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. SIGNATURE for CERTIFIER 20b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE for CERTIFIER 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	TENDING TOR: After after deatt 28 Is ma	0	3 Suicide 6 Could not be 26a. PLAC build	E OF INJURY — At hong, atc. (Specify)	ome, larm, street,				nd Number or Rural I	Route Number,
296. SIGNATURE ORD TITLE OF PERSON WHO COMPLETED CAUSE OF DESTRUCTION WHO CAUSE OF DESTRUCTION W	OR A DIRECT		29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the bea	t of my knowledge, da	ath occurred at	he lime, data a	and place, and due	in the cause(s) and many	ner se stated	
296. SIGNATURE ORD TITLE OF PERSON WHO COMPLETED CAUSE OF DESTRUCTION WHO CAUSE OF DESTRUCTION W	로 작전 =	COM	000) 2 MEDICAL EXAMINER: On the bests of							s) and manner as stated,
30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DESTRICTED 27 (Sing Order)	王 王 是 2	BE	29b. SIGNATURE AND TITLE OF CENTIFIER	TUDGE M	D			BER	29d. DATE SIGNED	(Month, Day, Year)
I II LOUVING I FUD " WALLE REVOLATE AFROM ON X LIVE III III III III IIII III III III III	7	¥	30. NAME AND ADDRESS OF PERSON WHO COMPLETED OF	. 1	1/	264.4	Homa 75	Lon Alu	Will Co	R 1621287
31. DATE FILED (Month, Day, Year) 12. REGISTRAR'S SIGNATURE MAY 2 3 1995 ALL Shutler Well	-			BAR'S SIGNATURE		-	Lespiyou	1 000 1000	OHEO!	Jamore

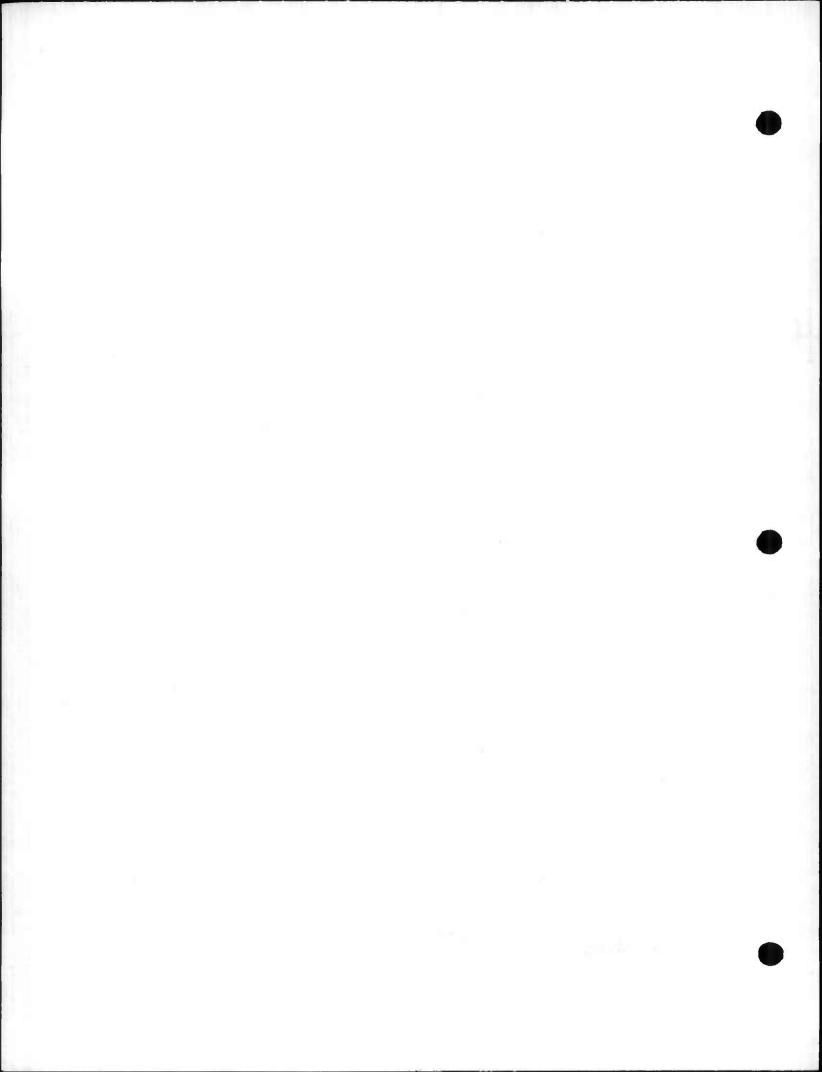


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31. DATE FILED (Month, Day, Year)
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12. REGISTRAR OSIGNATURE

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMI ERTIFICA			MENTAL HYGIEN REG. NO.	_	
J	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY YEA	3. TIME OF DEATH
1	JOE (NMN) CHARL	ES			MAY 19, 19		8:00 P.
		5. SEX 6. AGE (In yrs. le	MONT	INDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.8	IRTHPLACE (State or Foreign
		1X□ M 2 □ F 57	YRS.			08-04-1937		EXAS
۱ ـ	9a. FACILITY NAME (If not institution, give street				OR LOCATION OF DE	ATH	9c. COUNTY (
5	NORTH ARUNDEL HOSP	TTAL		GLEN 1	BURNIE	-	ANNE A	RUNDEL
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCA	TION			10d. INSIDE CITY LIMITS?
	MARYLAND AN	INE ARUNDEL	P	ASADE	NA			1 TYES 2 THE
¥	100. STREET AND NUMBER 7876 NEW FREETOWN	DOAD		10	f. ZIP CODE		1.0	OF WHAT COUNTRY?
FUNERAL					21122		U.S.	
- 1	1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 ☑ YES 2 ☐ IF YES, GIVE WAR OR DATES	NO	If yes, sp	pecify Cuban, Maxica	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	1	RACE — American Indian, Black, White, atc.
ĕ	3 Widowed 4 Divorced	1955-1969	1	1 [] YES	NO Specify	e e		Specify: WHITE
	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION 16a. DI	ECEDENT'S USUA			16b. KIND OF BUS	SINESS/INDUST	
5	Elementary/Secondary (0-12)	College (1-4 or 5+)	. Do NOT use retir	red.)	ost or working			
COMPL	12 N/	/A DE	PARTMEN	T HEA		STATE O		AND
- 1	17. FATHER'S NAME (First, Middle, Last) JOE	CHARLES				ME (First, Middle, Maiden		
B	19a. INFORMANT'S NAME (Type/Print)		DE MAILING ADD	BESS (Street)	EMMA	Route Number, City or Tow	URDIA	
임	SARAH J. CHARLES), PASADENA		•
	20e. METHOD OF DISPOSITION	20b.PLACE	AND DATE OF DIS	SPOSITION (N		OATE 20c. LO	CATION — City of	
	1 Donation 5 Other (Specify)	outrotory, or	ETERANS	CEME	TERY	5/23/ CR	OWNSVIL	LE. MD.
- 1	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		22. NAME A	ND ADDRESS OF FA	CILITY 993		
	· Atour	a constant	j	1 SEC	OND AVENI	SINGLETO		AL HOME, IE,MD. 210
	23. PART I. Enter the diseases, or cor	mplications thet coused the dest only one cause on each line	eeth. Do not a	nter the mo	ode of dying, such	h se cardiec or respi	retory arrest,	Approximate
	IMMEDIATE CAUSE (Finel	at only one cause on each line	в.					Onset and D
	disease or condition resulting in death) s.	MYOCARDIAL		TION				MINUT
		DUE TO (OR AS A CONSE		CEACE	-			YEARS
5	Sequentially list conditions, b.	DUE TO (OR AS A CONSE		JEASE				TEARS
4	If any, leading to immediata cause. Enter UNDERLYING	HYPERTENSION	N					YEARS
	that initiated events	DUE TO (OR AS A CONSE						
CERTIFICATION	resulting in death) LAST	DIABETES ME	LITUS					YEARS
AL C	PART II. Other significent conditions	contributing to death but not	resulting in the	e undarlyin	g cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FIND
3	CONGESTIVE CAR	OIOMYOPATHY				PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAL
MEDIC	HYPERCHOLESTER	EMIA					6,00	DF DEATH?
Z	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	ATH YES [] NO [UNCERTAIN	10		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLA	CE OF DEATH (C					
YSI	1 TYES DE NO	☐ Inpatient 2 ER/Outpatient :	DOA 4	_	ne 5 🗆 Rasidenca	8 Other (Specify)		
٦	27. MANNER OF OEATH 1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WC	JURY AT DRK?	28d. OESCRIBE HOW II	NJURY OCCURE	0
_	2 Accident Investigation	28a. PLACE OF INJURY — At he				28f. LOCATION (Street a	and Marshar on Co.	-10-11-1
B	9 Cudelde —	building, etc. (Specify)	,,,	, ractory, critic	-	City or Town, State)	Ind Number of HL	rer noute number,
ED BY	3 Suicide 6 Could not be detarmined							
ETED BY	4 Homicide detarmined	AN: To the heat of my knowledge of	eath occurred	the time des	and place and d	to the asserted that		
ETED BY	4 Homicide detarmined 29a. CERTIFIER (Check only) CERTIFYING PHYSICIA	AN: To the best of my knowledgs, do						ee(a) and manner as state
COMPLETED BY	4 Homicide detarmined 29a. CERTIFIER (Check only) CERTIFYING PHYSICIA	AN: To the best of my knowledge, di On the bests of examination and/or			death occured at the	time, data and placa, an	d dua to the cau	
ED BY	4 Momicide detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:					time, data and place, an	d dua to the cau	NED (Month, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH CREWS 05,1995 SHIRLEY MAY 17:13 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yea BIRTNPLACE (State or Foreign Country) 59 DAYS 1 M 2 XF october YRS 20, 36 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 201 N BROADWAY APT BALTIMORE 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore permit. 1 TYES 2 NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 201 N. Broadway #14A 21231 burial-transit Page 6 may be retained by the hospital or attending physician, 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married specify: black BY 3 Widowed 4 Divorced and completely filled in by the funeral director, page 5 should be detached for use as the burial, cremation, or removal. 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 16. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (full or 5 a) once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9 20s. METHOD OF DISPOSITION
1 Burlet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) In State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must ERAL SERVICE LICENSEE ROMALd Wade, Dir. examiner 21. SHOWNTURE OF FURN 22. NAME AND ADDRESS OF FACILITY State Anatomy Board hours after death. 655 W. Baltimore St., Balto., MD 212-1 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate ahock, or heart failure. List only one ceuse on each line. interval Batween MMEDIATE CAUSE (Fine) **Onset and Death** the requires that the death certificate be executed within 24 nase or condition NARCOTIC INTOXICATION resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician a Health and Mental Hygiene prior to If any, leading to immediate ceuse. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ö injury. PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The Item h the State HOSPITAL: OTHER: XXYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5 XResidence 6 ☐ Other (Specify) 0 27. MANNER OF DEATN 28a, DATE OF INJURY this (286 TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural Pending FOUND: 5/5/95 М 1 YES 2 NO UNKNOWN 5:00 P DIRECTOR; After the hours after death vitem 28 is man BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Burel Route Number, City or Town, State) 201 N. BROADWAY 3 Suicide COMPLETED 8 XXCould not be 4 Homicide HOME BALTO. CITY, MD 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 ho 2 💢 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF GESTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MAY 06,1995 OCME 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Baros OResu My 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1995 Michel

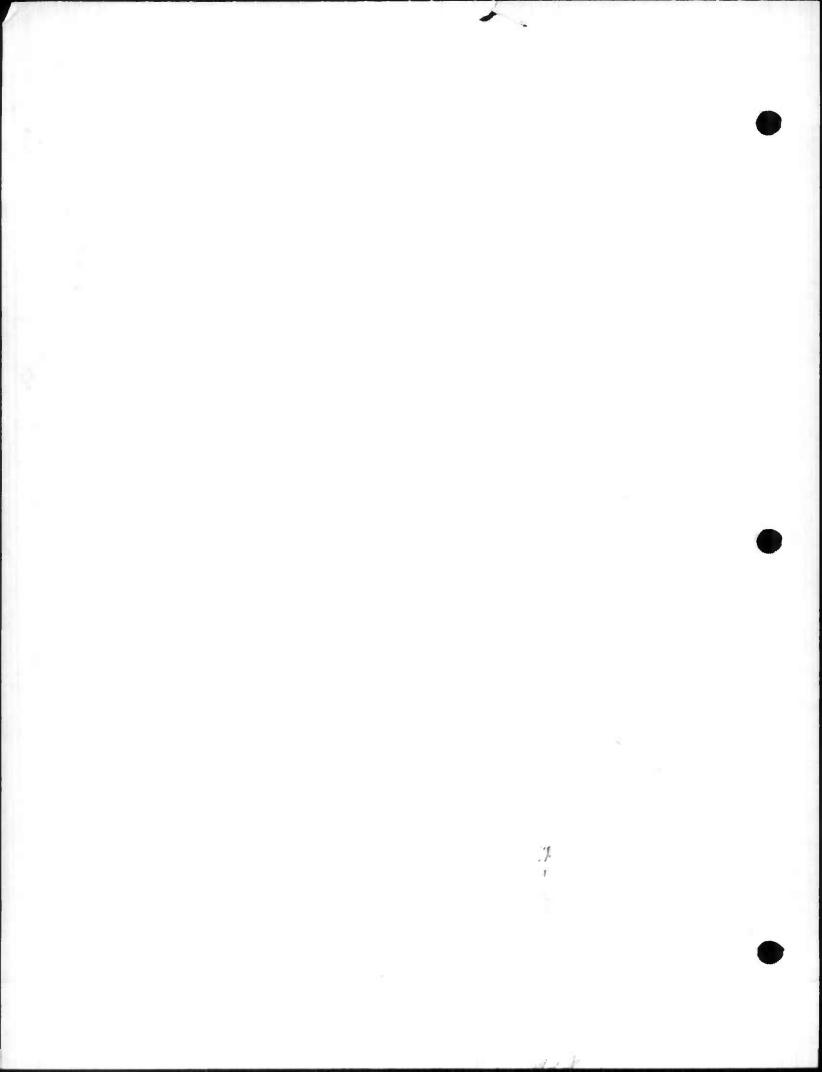
ospital or attending physician. ched for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

מולין וענון 'אוסוון' אוסוון	nours after death. Page 6 may be retained by the hospi	or removal.	medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within z4 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE	OF DEATH	DEC NO

	1 - FOR STATE REGISTRAR	TE OF MARYLANI) / DEPARTM	ENT OF H	EALTH AND		GIENE		
	1. DECEDENT'S NAME (First, Middle, Lest)	COLLINS				2. DATE OF DOMONTH		YEAR	3. TIME OF DEATH 2.30 PM
	- 13	1 2 F	98 YRS. MON	NDER 1 YEAR THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BE (Month, Day, Jan. 25	RTH Year)	6. BIRTH	IPLACE (State or Foreign y) aryland
TOR	9a. FACILITY NAME (if not institution, give street and Good Samaritan Hosp.5				altimore	EATH		NTY OF D	EATH
DIRECTOR	10e. STATE 10b. COUNTY Maryland		Balt:		TION				10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 1801 Wentworth Road			101	21234		10g. CITI		S.A.
BY	1 Never Married 2 Married FOI	S DECEDENT EVER IN U.S. RCES? 1 TYES 2 (ES, GIVE WAR OR DATES	ARMED XNO	If yes, sp	ENDENT OF HISPA ecify Cuban, Maxic 2 NO Specif	en, Puerto Ricen,	etc.)	14. RACE Black Speci	- American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	d) e (1-4 or 5+)	Give kind of work of life. Do NOT use retir	one during mo ed.)	DN st of working	16b. KIND	OF BUSINESS/IND	JUSTRY	
OM	17. FATHER'S NAME (First, Middle, Last)		lomemaker		18. MOTHER'S NA	AME (First Middle	Maiden Sumame)		
ш	Frank Broaders					Gouger	maioen Surraine)		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD						
	Norman Collins		1631 Cot	tage	LA., Bal	timore,	MD 2120)4	
	20a. METHOD OF DISPOSITION Burlet 2 Cremetion 3 Removal from Donetion 5 Other (Specify)	n Stata cemetery.	CE AND DATE OF DIS crematory or other pl	ece)			20c. LOCATION —		.,
	21. SIGNATURE OF DUNERAL SERVICE LICENSEE	lace		655 W	. Baltim	ore St.	e Anatom , Balto.	, MI	
ATION	23 PART I. Enter the disesses, or complice shock, or heart fellure. List only immediate condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	UE TO (OR AS A CONDUE TO (OR AS	DIAL SEQUENCE OF):	INFA	ACTION	V WITH			Approximate interval Between Onset and Death
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CON	SEOUENCE OF):						
PHYSICIAN: MEDICAL C	PART II. Other significent conditions contributing to dasth but not resulting in the underlying cause given in Part i. S'YPRA - VEN THE CULAR APRHYTHMIA 1 YES 2 YNO						24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 THO	
AN	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL		EATH YES		UNCERTAI	N 🗆			
SICI	EXAMINER? HOSE	PITAL: petient 2 ER/Outpetient	ОТІ	IER:	* C =		ā.		
Ĕ		a. DATE OF INJURY	26b. TIME OF	26c, INJI	5 Residence		HOW INJURY OCC	URED	
BYF	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		RK7 ES 2 NO				
							oute Number,		
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To Description on the control of the co	the best of my knowledge, basis of examination and	death occurred at t	he time, data ny opinion, de	and place, and due	to the cause(s) a	and manner as state	ed. e cause(a)	and menner as stated.
BE	296. SIGNATURE AND TITLE OF CENTIFIER Dalute.	MO DEP	ESIDENT TOF ME	-D.	29c. LICENSE NUI	134	10000		(Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO COMPL TOSEPH BOATENG A	TED CAUSE OF DEATH (TEM 27) (Type, Print)						,,,,,,
	31. DATE FILED (Month, Day, Year) MAY 2 3 1995	REGISTRAR'S SIGNATUR	Lall.						



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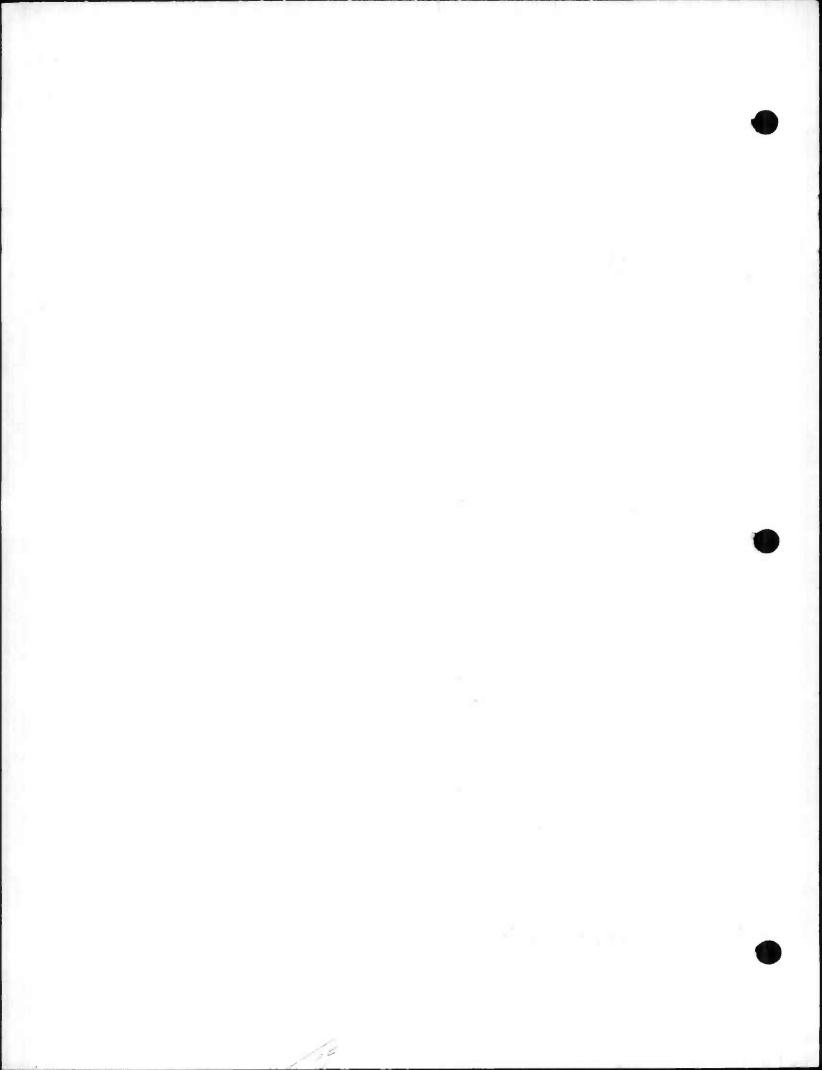
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MAY 2 3 1995

		1	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN		
			1. DECEDENT'S NAME (First, Middle, Last) CATHERINE E	EASTER				2. DATE OF DEATH MONTH D	AY YEA	
			4. SOCIAL SECURITY NUMBER 250-08-0013		(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. B	IRTNPLACE (State or Foreign Duntry)
	. 2, 3 should	SI OH	98. FACILITY NAME (If not institution, give str	ctical Cen	uter	96. CITY, TOWN O	OR LOCATION OF D		Sc. COUNTY	PF OEATN
	200	DIRE E		(A	10c. CIT	y, TOWN OR LOCAT	OSE			10d. INSIDE CITY LIMITS? 1 YES 2 NO
		FUNERAL	3754 Dolf	reld Aug	ل.	101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
P g		2	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, spi	ENDENT OF NISPAL Inclination of Nicolar 2 NO Specific	NIC ORIGIN? (Specify Yes in, Puerto Ricen, etc.) y:		Black, White, etc.
9 (0)	g 11		15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATION	N st of working	16b. KIND OF BUS	SINESS/INDUSTP	W .
M B			Elementary/Secondary (0-12)	College (1-4 or 5+)	54	uden	+	Col	lege	>
RYLAI ad by the h	5 76 1	- 19	17. FATHER'S NAME (First, Middle, Last)	s ter			18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)	
MAR	notified	01	190. INFORMANT'S NAME (Type/Print)	\	19b. MAILING 3 49	ADDRESS (Street a)	nd Number of Rural	Route Number, City or Town	n, State, Zip Code	5 (29742
ج بر 8	2	-	200, METHOD OF DISPOSITION	Man T 206	911	OF DISPOSITION (Ne	me of		CATION - City o	0.(. 1/12
9 9 E	or must		1 Soundtine Of Funeral Service Lice		etery, crematory or o	h Ce	metery	5/27/8 SI	Janin	, S, C,
de ath	examin		· Glynia	B. Su	D.	March 4300		al Home-	Wyst Dal	to 4d
urs af	edic	ı	23. PART & Enter the diseases, or or shock, or heart failure. L	omplications that ceused lat only one cause on e	the death. Do i ach line.	not enter the mod	de of dying, auc	h aa cardlac or respi	ratory arrest,	Approximate interval Between
ithin 24 ho	no.		IMMEDIATE CAUSE (Final disease or condition resulting in death)			IAL 1	FAILUI	RE		Onset and Death
executed within	5 2 2				CONSEQUENCE OF	,				
be se	traumati		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF		Onl.			
ertification	Hygiene p		CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ā:				
death c	- I II		d.					y Syno.	RomE	
lires that the	ws any I		PART II. Other algorificant conditions	contributing to death b	ut not reaulting	n the underlying	cause given in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
AL ME	St. of		DID TOBACCO USE CONTR				UNCERTAIL	V 🗆		1 TYES 2 NO
	d, or item			HOSPITAL:	26, PLACE OF DEAT	OTHER:				
PHYSICIAN:	with the State ted, or Rem		27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JRY AT	6 Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCURED)
ATTENDING P	Is mar		1 K Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, stc. (Spec	— At home, farm, a		ES 2 NO	281. LOCATION (Street e City or Town, State)	nd Number or Ru	ral Route Number,
OR ATT	hours after 18 Item 28			IAN: To the heat of and						
HOSPITAL	2 = 3		(Check only one) 2 MEDICAL EXAMINER	IAN: To the best of my know : On the basis of examination	euge, death occurry n end/or investigatio	n, in my opinion, de	end place, end due eath occured at the	to the cause(s) end men time, date end place, end	her es stated. Il due to the ceur	ee(s) end manner es atated.
유	RTANT:		296. SIGNATURE AND TITLE FOCERTIFIER				29c LICENSE NUE		204 DATE SICA	

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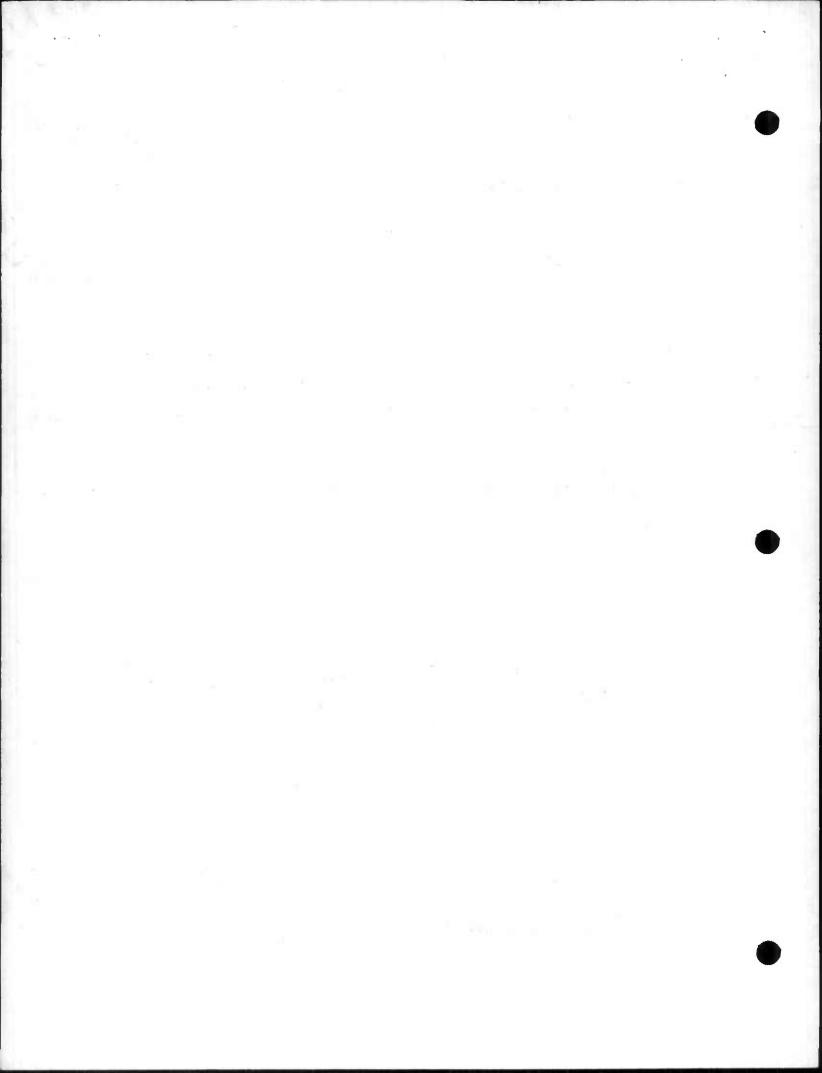
IL, MD, 76 CRANBROOK RD, SUITE 168, COCKEY SVILLE, MO 21030

MAY 20 1995



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-	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	EVINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct
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	1. DECEDENT'S NAME (First, Middle, Last)	4 FOW	50					2	DATE OF DEATH	7 0	VEAR 450 Q
	4. SOCIAL SECURITY NUMBER 216-03-9824	5. SEX 1 M 2 F	6. AGE (In yrs. le 76		IF UNDER 1	YEAR DAYS	IF UNDER HOURS	24 HRS. 7	Month, Day, Year) Sept. 21,	191	ls. BIRTHPLAGE (State or Foreign Country) Maryland
TOR	90. FACILITY NAME (If not institution, give Howard County Gen		oital				bia	N OF DEAT	Н		nty of DEATH Oward
DIRECTOR	10e. STATE 10b. COUNT	timore Co	ounty	1	y, town or anda1						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10. STREET AND NUMBER 3454 Carrage Hill	Cir. Tl				101	211		To	10g. CiTi	ZEN OF WHAT COUNTRY? U.S.A.
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, OIVE W WWI]	AR OR DATES	RMED NO	ff's	/es, sp	ENDENT O	, Mexican, F	ORIOIN? (Specify Yes uerto Rican, etc.)	or No-	14. RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDI. (Specify only highest gradi Elementary/Secondary (0-12) 12 Years		-)	Give kind of a. Do NOT u	USUAL OCC work done du se retired.)	UPATIC ling mo	ON st of working	7	Self Em		
BE CON	17. FATHER'S NAME (First, Middle, Lest) William E. Fowler				16. MOTHER'S NAME (First, Middle, Melden Surneme) Elsie L. Jones						
5	190. INFORMANT'S NAME (Type/Print) Mrs. Rosalie Fowl	er		3454	Carra	age	Hill	or Runal Rou Cir	Number, City or Tow T1 Ra	n, Stote, Zip nda11	Lstown, MD 2113
	20a. METHOD OF DISPOSITION 1 N Burlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		20b. PLACE cometery, crit Loudo	and Date	22. NA	nete	ery	S OF FACIL	9/95 Ba	1timo	ore, MD
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO	ESTIVE (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE	OUENCE O	n GRÖ	no	- 1	12A	er Dus	EAS	E 2da
	PART II. Other algnificant condition DOSSIBLE C AENAL DID TOBACCO USE CONT	FAILUR	51 1	Ch	RON	1C			PERFOR	MED?	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100	HOSPITAL:	26. PLAC	CE OF DEAT	OTHER:	y one)		RTAIN	Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF (Month, De	ey, Year)		E OF 20	Bc. INJU WOI 1 _ Y	JRY AT RK? 'ES 2	26	d. DESCRIBE HOW II	NJURY OCC	CURED
BY	3 Suicide 6 Could not be 4 Homicide determined	building,	FINJURY — At he etc. (Specify)						City or Town, Stete)		or Rural Route Number,
	29a CERTIFIER			eth occum	d at the time						ed.
		ER: On the basis of ex				ilon, di	eth occure	d at the tim	e, dete end place, en	d due to th	e couse(s) end menner es stated
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2. DATE OF OEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH

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Am car razi eR 5-19 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-18-1466 CHTHO DAYS HOURS MIN. 1 M 2 M F MD Pages 1, 2, 3 should 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Garden Nursing DIRECTOR Dro more N/A RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10d. INSIDE CITY MD N/A BALTIMORE CITY XXYES 2 NO permit. 10s. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? burial-transit 1012 E. 20TH STREET 21218 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puarto Ric 1 YES 2 NO Specify: 1 Never Married 2 Married BY Black 3 Widowed 4 Divorced use as the ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A HOUSEWIFE HOME notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Jones BETHA JONES 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BERNARD FRAZIER 1012 20TH ST. BALTIMORE, MD. 21218 20e. METHOD OF DISPOSITION
1 M Burlel 2 Cremetton 3 Removal from State
4 Donatton 5 Other Secret e 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata must funeral director, GARRISON FOREST VA 5/24 OWINGS MILLS, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME The 1129 N. CAROLINE ST. BALTO, MD21213 and completely filled in by the 1 bunal, cremation, or removal medical 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death the executed within 24 disease or condition Idvanced whemic cardiomyopath event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): oronary artery disea traumatic CERTIFICATION Sequentially list conditions, prior to If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by t AVAILABLE PRIOR TO COMPLETION OF CAUSE any 1 YES 2 NO OF DEATH? shows ; Chronic grationitestinal hemorrhage Cognitive dustanction 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h EXAMINER? HOSPITAL OTHER:
4 Nursing Homa 5 Residence 6 Other (Specify) OR ATTENDING PHYSICIAN: 1 Inpetiant 2 ER/Outpetiant 3 DOA - the 27. MANNER OF DEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 28e. DATE OF INJURY (Month, Day, Year) 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY After t Investigation 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide - 60 6 Could not be DIRECTOR: A COMPLETED 4 Homicide 28 determined Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the beals of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Yell)

5/19/95 29c. LICENSE NUMBER BE Soston 102486 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Boston Harford Gardens Nursing Home 32. REGISTRAR'S SIGNA 31. DATE FILED (Month, Day, Year) his Shudear Re MAY 2 3 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DIRECTOR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	4
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TO THE FUNERAL C
DE filed within 72 h
IMPORTANT: If It

95 15707 ITEM: 19a, PER F.H. FILM G-723 5/23/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR FREYDIN 4. SOCIAL SECURITY NUMBER MAY 17,1995 8:39pm 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MARCH 9,1910 DAYS HOURS 1 M 2 F 85 MIN. RUSSTA YRS. 216-37-1645 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE 1 YES 2 X NO 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2 RUSSERN CT, APT. T-3 21215 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— It yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 2 XNO Specify: 3 Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 4 **ENGINEER** MEDICAL 17. FATHER'S NAME (First, Middle, Last) 1a. MOTHER'S NAME (First, Middle, Maiden Surname) YEDKA FREYDIN TZIPA **BRODSKAYA** 190. INFORMANT'S NAME HRS. RAKHIL RATNER 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. RAHKTL RATNER 2 RUSSERN CT, APT. T-3 BALTIMORE, MD 21215 20a. METHOD OF DISPOSITION 1 № Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State ARLINGION-CHIZUK AMUNO- 5-19-1995 BALTIMORE, MD 4 Donation 8 Other (Specify) THE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE 23 PART I Enter he diseases, or complicatione that coused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, of heart fallure. List only one cause on each line. Interval Between IMMEDIATE CADGE (F)nei Onset and Death disease or condition corouary resulting in death) DUE TO (OR AS A CONSEQUENCE OF): leevir heen Sequentielly ilst conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate POP cause. Enter UNDERLYING CAUSE (Disease or injury **OUE TO (OR AS A CONSEQUENCE OF)** that initiated eventa resulting in deeth) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 260. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY Month, Day, Year 1 Netural м 1 YES 2 NO Investigation 2 Accident 26e. PLACE OF INJURY — At home, term, street, tactory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Vickoula TSI ► 5/18/95 D34878 ULD. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH OTEM 27 (1904. P.

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3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Penney lang

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 X YES 2 | NO

1-6006

Approximeta

Interval Between

Onset and Death

4 days

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 - YES 2 NO

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2. DATE OF DEATH

MONTH 5

FOR STATE

REGISTRAR

Jessie

1. DECEDENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8 -05-10-12 permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FIMORE EDENT Oe. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION timore FUNERAL 100. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3/3/5 hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit Q 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Merried If yes, specify Cuban, Mexicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO 87 Specify: 3 Widowed 4 Divorced G 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY COMPLET (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) 10 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surna notified at 38 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City 2 59 pe 20e, METHOD OF DISPOSITION
1 Street Burlet 2 Cremetton 3 R Burlet 2 Cremetton 5 R Donatton 5 Other (Specify) METHOD OF DISPOSITION
Burlel 2 Cremetion 3 5/26/ 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, State must Removal from State examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4611 Pas nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. 0 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ehock, or haart fallure. List only one ceuse on **IMMEDIATE CAUSE (Fine)** disease or condition ia betic Ketoacidosis traumatic event, resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF): iabetes CERTIFICATION THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bur Sequentieily list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate 2 cause. Entar UNDERLYING the death certificate other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events reaulting in death) LAST 0 Injury. PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? Accident requires that Cerebrovascular shows any 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) HOSPITAL DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) tem HOSPITAL: EXAMINER? OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? marked, 28d, DESCRIBE HOW INJURY OCCURED Netural
Accident 5 Pending м 1 YES 2 NO 8 Investigation 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 28 Is r 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide e Could not be COMPLETED 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTI DE filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 MEDICAL EXAMINER: On the on end/or investigation, in my opinion, death occured at the time, date and place, and dus to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 8 2 PERSON WHO COMPLETED CAUGE OF DEATH-(ITEM 27) (Type, Print) MP

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

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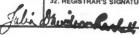
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 meurs after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Poe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH helma YEAR (sample 95 05 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) April 15, IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 220-01-5495 Virginia 1 M 2 F 85 DAYS HOURS 191d 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Caton Manor Nursing Center DIRECTOR Baltimore City N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. N/A Baltimore City YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 132 Allendale Street 21229 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuban, Maxican, Puarlo Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY IF YES, GIVE WAR OR DATES 1 YES 2 TO NO Specify 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ost of working Elementary/Secondary (0-12) College (1-4 or 5+) 8th Housekeeper Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas Greenwood Mamie Pratt 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eva L. Gambrell 8035 Williams Ave. Philadelphia, Pa. 19150 20s. METHOD OF DISPOSITION

1 X Burlel 2 Cremetion 3 Removel from State
4 Donatton 5 X Other (Specify) LT COMDITION 1 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata Woodlawn Cemetery May 22, 1995 Woodlawn, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSIEE 22. NAME AND ADDRESS OF FACILITY Caple Funeral Service 5502 Winner Avenue Baltimore, Md. 21215 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease pr condition LDSis en days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (94) AS A CONSEQUENCE OF): left lower extremi ew day CERTIFICATION Sequentially list conditions, If any, leading to immediate cause Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH? 1 TES 2 NO Vasandar disease 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 TYES 2 NO OTHER: ne 5 🗆 Rasidence 8 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending 1 YES BY 2 NO 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 8 Could not be determined 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) May 19,1995 Lan D-40521 2

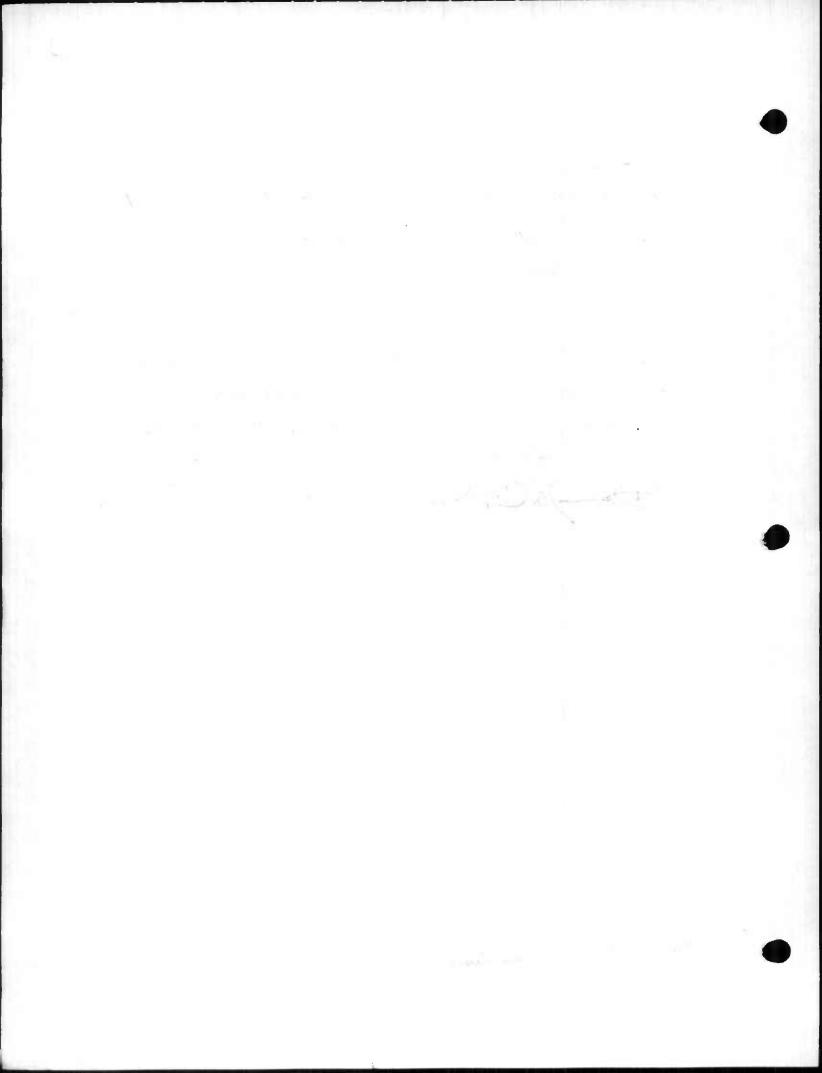
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 33.50 WILKENS AVENUE SUITE 3 DR MAHESH S. OCHANES BALTIMORE, MD 2122 32. REGISTRAR'S SIGNATURE



31, DATE FILED (Month, Day, Year)

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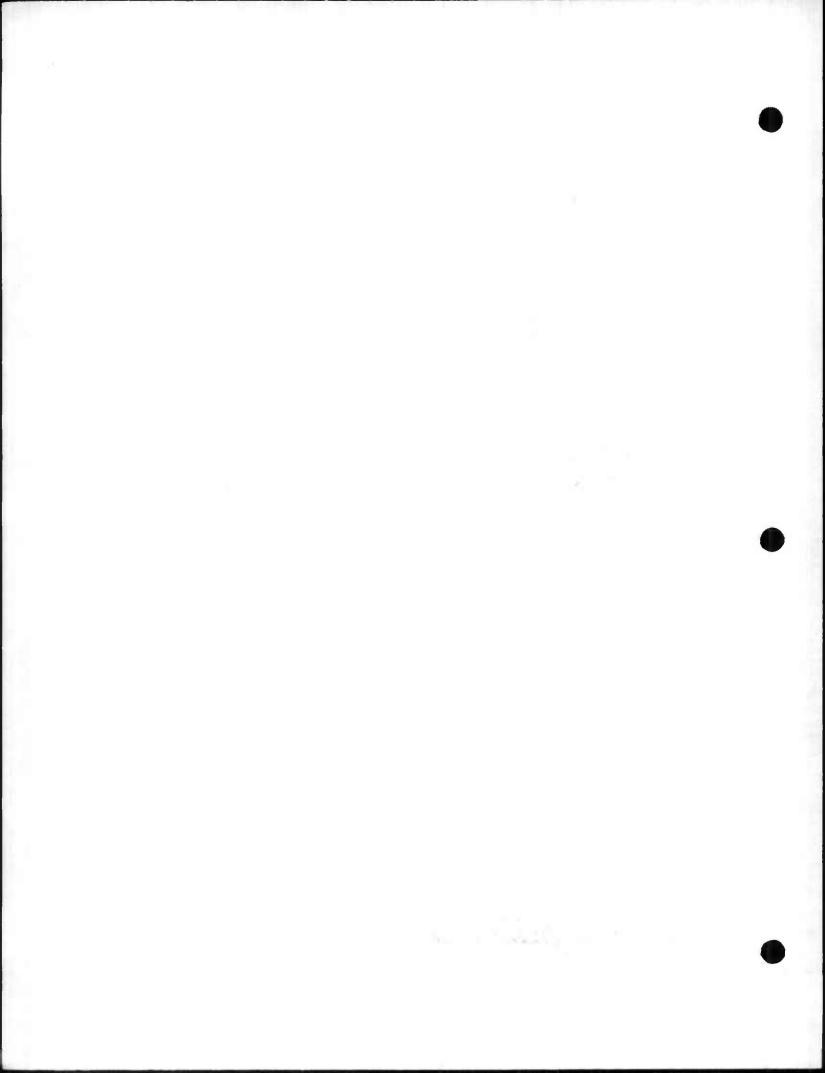
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS. P.O. BOX 68760

7	deat	
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	hours	
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	with	
	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death	
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	tificate	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	ANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Maude	Fahan	Cmaan			2. DATE OF DEATH MONTH D	AY YE	3. TIME OF DEATH	
		Ester	Greer				995	9:15 P M	
	218-32-6063	1 D M 2 DF 76	YRS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan. 18,	919	BIRTHPLACE (State or Foreign Country) VIRGINIA	
œ	9a. FACILITY NAME (If not institution, give stre 708 Upper Glen		9		R LOCATION OF D	EATH	9c. COUNTY		
6	RESIDENCE OF DECEDENT	Coe Ru.		Spar	KS		BALT	IMORE	
DIRECTOR	MARYLAND BALTI	MORE	11.0	OWN OR LOCATI	ION			10d. INSIDE CITY LIMITS? 1 YES 2X NO	
FUNERAL	100. STREET AND NUMBER 708 Upper G	longos Pd		101.	ZIP CODE			OF WHAT COUNTRY?	
JNE		12. WAS DECEDENT EVER IN U.	e ADMED	T 42 WES DECI	21152		US		
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 N/Q	It yes, spe 1 TYES	city Cuban, Maxica	NIC ORIGIN? (Specity Yearn, Puerto Rican, stc.) fy:		RACE — American Indian, Black, White, atc.	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	Sa. DECEDENT'S US (Give kind of work life. Do NOT use n	done during mos	N It of working	16b. KIND OF BU	SINESS/INDUST	TRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) n/a	Homema			Own	Home		
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden			
BE C	James R	. Jones			Sarah	Hannah Atk	ins		
10	19a. INFORMANT'S NAME (Type/Print) Jesse Edgar G	reer				ne,#706,Ea			
	20a. METHDD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramov	20b, PL	ACE AND DATE OF D	DISPOSITION (Next		DATE 20c. LO	CATION — City		
	4 Donation 5 Tither (Shelly)	Jes	ry, crematory or other SOP Ceme		D ADDRESS OF FA		keysvil	lle, MD	
	X Deriver 1	emmon length	00	Lemmon	Funera	1 Home of	Dulaney	Valley, Inc.	
-	22. PART L Erfer the diseases, or cor	mplications that caused th	e daath. Do not	antar the mod	Padonia le of dying, suc	Rd., Timo	ratory arreat.	Approximate	
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) e								
	DUE TO (ON AS A CONSEQUENCE OF):								
NOL	Sequentially list conditions, if any, leading to immediate DUE TO (DR AS A CONSEDUENCE DF):								
2	cause, Enter UNDERLYING CAUSE (Disease or injury								
CERTIFICATION	that initiated events DUE TO (DR AS A CONSEDUENCE OF): resulting in death) LAST								
AL CI	PART II. Other aignificant conditions	contributing to deeth but	not resulting in t	ha undarivino	cause given in	Part i. 24a. WAS AN	ALITOPEY	24b. WERE AUTOPSY FINDINGS	
SICA			•		group m	PERFOR	ED3	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEC							4	OF DEATH?	
ä	DID TOBACCO USE CONTRI			4	UNCERTAIL	N 🗆		0	
PHYSICIAN: MEDIC		HOSPITAL:	PLACE OF DEATH (THED:	1				
HYS	1 TYES 2 NO 1	28s. DATE DF INJURY	nt 3 DOA 4			6 Other (Specify) 28d. DESCRIBE HOW II	I I III OCCUPE	70	
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOR		Edd. DESCRIBE NOW II	SONT OCCURE		
COMPLETED B	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, stree	et, factory, offica		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
Z.E.	29s. CERTIFIER Check only	AN: To the best of my knowledg	e, death occurred a	t the time, date a	and place, and due	to the cause(s) and man	nos en elelad		
OM	one) 2 MEDICAL EXAMINER:	On the basis of examination an	d/or investigation, in	n my opinion, de	ath occured at the	time, data and place, an	d dus to the cau	use(s) and manner as stated.	
w II	296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUM			NED (Month, Day, Year)	
TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (France Print	77)	021	242	· 5.	-1295	
	Harvey Mischner.				J	21002			
	31. DATE FILED (MONTH, Day, Year) MAY 2 3 1995 July	32 REGISTRAR'S SIGNATU		Timon	ium, MD	21093			



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31. DATE FILE 23 1995

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for usi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	ITEM: 18. PER F.H	. FILM 6-723	5/23/9	95 t.t					9	5	15/1	
	FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPART	MENT OF	HEAUTH AND F DEATH	MENT	AL HYGIEN				•
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS SYLV	ESTER		G	AFFIC	GAN	2. DAT MON MA	_	199	YEAR 5	3. TIME OF DEATH	Ам
	131-03-4630	X M 2 □ F	(In yrs. lest 74		IF UNDER 1 YEAR		7. DAT	E OF BIRTH rith, Day, Year) 23 1		8. BIRTH	PLACE (State or For	eign
TOR	90. FACILITY NAME (If not institution, give street HOPKINS - BAYVIEW RESIDENCE OF DECEDENT		CENT			OR LOCATION OF	DEATH		9c. COU	N/A		
DIRECTOR		TIMORE		10c. CITY,	DUNDA						10d. INSIDE CITY LIMITS? 1 YES 2 X I	NO
FUNERAL	100. STREET AND NUMBER 3305 LIBERTY PA					101. ZIP CODE 21222				U.S	A.	
B≺	1 Never Married 2 A Merried 3 Widowed 4 Divorced	P. WAS DECEDENT EVER II FORCES? 1X YES IF YES, GIVE WAR OR O W W II	2 N		If yes,	ECENOENT OF HISP/ specify Cuben, Mexic ES 2 X NO Spec	can, Puerto	ilN? (Specify Ya o Rican, etc.)	s or No—	14. RACI Black Spec	E — Americen Indiesk, White, etc. #y: WHITE	A,
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5+)	(Giv	EDENT'S U e kind of wo Do NOT use	retired.)	TION most of working	16	Sb. KIND OF BU	SINESS/INC		ry	
BE COM	17. FATHER'S NAME (First, Middle, Leat) SYLVESTER GAFFIGAN				TRESIC	18. MOTHER'S N			Sumeme)	RY PA		
2	190. INFORMANT'S NAME (Type/Print) THERESA RIETZKE		3	305 I	IBERT	Y PARKWAY					21222	
	20e. METHOD OF DISPOSITION 1 Burlel 2 Commellon 3 Removal 4 Donation 5 Other (Specify) 21. Signature Of Funeral Service Licens	from State Con			CREMA		22-9		LTSVI		MARYLAN	D
	· Hallen A	ash			BRAI 2134	DLEY-ASHT	ON F	NG RD.	BAT.	T.		.2
	23. PART i. Enter the diseases, or come shock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	pplications that caused tonly one causa on e	ve A	rter							Approxima interval Be Onset and	twee! Deat
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events are consequence of the condition of the condit											
בעו	that initiated eventa resulting in death) LAST	552 10 (511 76) 7	CONSECU	JENCE OF).								
PHTSICIAN: MEDICAL	PART ii. Other aignificant conditions c	ontributing to death b	out not re	aulting in	the underly	ing cause given in	n Part í.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FIN AMAILABLE PRIOR TI COMPLETION OF CA OF DEATH?	0
MAIN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN TO SPECTED 1 VES 2 1/2 NO UNCERTAIN TO S											
- 1	EXAMINER? X YES 2 NO				Outpetient 3 DOA 4 Nursing Home 5 Residence RY 28b. TIME OF 28c. INJURY AT				NJURY OC	CURED		
10 03	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, stc. (Spec	— At hom	e, farm, str		YES 2 NO	281, LO	CATION (Street and your Town, Stete)	and Number	or Rural F	loute Number,	
COMPLETED OF	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN DESCRIPTION ON DESCRIPTION OF CONTROL OF CON	N: To the bast of my know) end manner ee sta	rted.
30 00	296. SIGNATURE AND TITLE OF CERTIFIER J. HAME AND ADDRESS OF PERSON WHO CO	Keng.	nu	1).		29c. LICENSE NU	MBER		29d, DAT		(Month, Day, Year)	

Penn Street, Baltimore, Maryland 21201

**

ITEM: 4. PER INFORMANT FILM G-743 1/13/97 t.t

STATES OF THE COLDS, F.C. BOX 66700 BALLIMORE, MANTLAND ZIZIS-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 15712

	1 - STATE REGISTRAR		FICATE OF		MENIAL HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last)			OLA III	2. DATE OF DEATN		3. 1	TIME OF DEAT	ΓN
	KATHERINE JOHNSON	1	G:	ROSS		4	95 5	:39	P
		AGE (In yrs. lest birthday		IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLAC	DE (State or Fo	oreign
	443-34- 9634 9624 1□ m 2 🔭	59 YRS.	MONTHS DAYS	HOURS MIN.	Feb 10,	1936	Country) OK		
_	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF DI	ATN		TY OF DEATH	ı	
6	NORTHWEST HOSPITAL CENT	ER	RANDA	LLSTOWN		BAL	TIMO	RE	
EC	10a. STATE 10b. COUNTY		TY, TOWN OR LOCA	TION			104	. INSIDE CITY	,
DIRECTOR	OK Comanche	I	Lawton				1000	LIMITS?	
	10e. STREET AND NUMBER		10	of, ZIP CODE		10g. CITIZI	EN OF WHAT	0	NO
ER	2304 NW Redwood Lane			73505			USA		
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EV 1 Never Married 2 Statement FORCES? 1	ER IN U.S. ARMED	13. WAS DE	CENDENT OF NISPAN	IIC ORIGIN? (Specify Yes	or No-	14. RACE - A	merican India	en,
ВУ	1 Never Married 2 Married FORCES? 1 IF YES, GIVE WAR 6			S 2 XNO Specifi	n, Puerto Rican, etc.)		Black, Wh	lack	
	15. DECEDENT'S EDUCATION	180 DECEDENT	S USUAL OCCUPAT	1011		1		Tack	
	(Specify only highest grade completed)	(Give kind o	f work done during muse retired.)	ost of working	16b. KIND OF BUS	SINESS/INDU	STRY		
Ī	Elementary/Secondary (0-12) College (1-4 or 5+)		naker		JO.	vn Ho	me		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NA	ME (First, Middle, Maiden				
BE	William Walker			Helen	Kidd				
10 8	19e. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n. State, Zip (Code)		
h-	Thomas M. Gross	2302	4 NW Re	dwood L	ane, Lawi				
	20s. METHOD OF DISPOSITION 1 Direction 3 Removal from State 4 Donation 6 Other (Specify)	Sunset (DATE 20c. LO			State	
	4 U Donation 6 U Other (Specify)	Sunset (ND ADDRESS OF FA	-22-95 Lav	vton,	OK		
	Del-MAR	A4			shton Fur on Avenue	neral	Home	e	
Щ	Ball Clura	M00930						Md 2	2122
	23. PART I. Entar the diseases, or complications that cs shock, or heart fallure. List only one cause of	used the deeth. Do on each line.	not enter the m	ode of dying, suc	h as cardlec or respi	ratory arre	st,	Approxima	
	IMMEDIATE CAUSE (Fine)								
	resulting in death) a. Caralac arhythmia								
_	disease or condition resulting in desth) a. (ardiac arhythmia DUB TO (OR AS A CONSEQUENCE OF): b. Procurdial fibras is QUE TO (OR AS A CONSEQUENCE OF):								
흔	" only leading to intinodiate								
₹	Cause. Enter UNDERLYING CAUSE (Disease or injury								
빌	that initiated events resulting in death) LAST	AS A CONSEQUENCE	OF):						
CERTIFICATION	d								
	PART ii. Other significent conditions contributing to dee							E AUTOPSY FI	
MEDICAL	Hypertensive allers	coronz	Cardio	vosculu	PERFOR		COM	LABLE PRIOR I PLETION OF C DEATH?	
ME	disease							YES 2 1	NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		OTHER:						
IXS	1 X YES 2 NO 1 inpetient 2 XER		4 - Nursing Nor	ne 6 🗆 Residence					
	27. MANNER OF DEATH 28e. DATE OF INJU (Month, Day, 16		IJURY W	JURY AT ORK?	28d. DESCRIBE NOW II	NJURY OCCU	JRED		
ВУ	2 Accident Investigation 3 Suicide 8 Could are be 28e. PLACE OF IN.	JURY — At home, term,		YES 2 NO	POLITICAL (Communication)			715-00	
COMPLETED	4 Homicide S Could not be building, etc.	(Specify)	acteur, tactory, orn		281. LOCATION (Street a City or Town, State)	ina Number o	r Hurai Houle	Number,	
9	29s. CERTIFIER (Check only	raciniarine deeth econo	med at the time dat						
)MP	(Check only one) 2 X MEDICAL EXAMINER: On the beals of examile							menner as si	Interl
	29b. SIGNATURE AND TITLE OF SERVICIER	1		29c. LICENSE NUM					
BE	4766	1		O.C.M.			SIGNED (Mon		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	F DEATN (ITEM 27) (Typ	e, Print)	0.C.M.	·	IIA			
	David R Powler	111 P	enn St	reet, Ba	altimore,	Mar	yland	1 212	01
	31. DATE FILED (Month Day 1995	S ATURE C							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit pe filed within 72 hours after death with the State Debt of Health and Mental Hydiere brior to buriat, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TAL DR ATTENDING PHYSICIAN; T	VAL DIRECTOR: After this certificate 72 hours after death with the State	If item 28 is marked, or ite
TO THE HOSPI	TO THE FUNER be filed within	IMPORTANT

BE 2

31. DATE FILED (Month, Qay, Year)
MAY 23 1995

Pages 1, 2, 3 should

ITEM: 16a, PER F.H. FILM G-723 5/23/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Mic 2. DATE OF DEATH 3. TIME OF DEATH FR 6 620Am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) OF b. th, Day, h. IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 321-14-6372 86 1 M 2 X F DAYS HOURS Oct. 1908 Alabama 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Lorien Nursing Home DIRECTOR Columbia Howard RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Ellicott City 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 4244 Lilac Lane 21042 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: BY Specify: Black 3X Widowed 4 ☐ Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Assistant Assistant Health Care 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) William O. Pearson Sophie Murphy BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4244 Lilac Lane Ellioctt City, Maryland 21042 2 Beverly Cole Henderson 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetery or other place). May 25, Mount Glenwood Cemetery, 20a. METHOD OF DISPOSITION
1

Burlel 2 □ Cremation 3 □ Removal from State 1995TE 20c. LOCATION - City or Town, State 4 Donation 6 Other (Specify) Chicago, Illinois 21. SIGNATURE OF EMISERAL DERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes uscella 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the diseases, or complications that esused the death. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Finel Onset and Death DEHYORATION
DUE TO (OR AS A CONSEQUENCE OF):
DY SOLTAGO A
DUE TO (OR AS A CONSEQUENCE OF):
BILATERA CERO disease or condition IWK resulting in death) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING ATERAL CEREBRAL INFARCTIONS CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? JEMENT! 1 TYES 2 NO OF OEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetlant 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a CERTIFIER CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On stigetion, in my opinion, death occured at the time, date and placa, and due to the cause(s) and manner as stated,

> MAURER 9501 OLD 32. REGISTRAR'S SIGNATURE

will mountain the strong

death. Page 6 may be retained by the hospital or attending physiciar	furnished discounts over E should be detected for one or the formal
hours after	lad in hy the
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a	DIRECTOR: After this cardificate has been eithed for the attending physician and completely filled in the funeral directors come 5 should be detected for une or the human base.
	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician

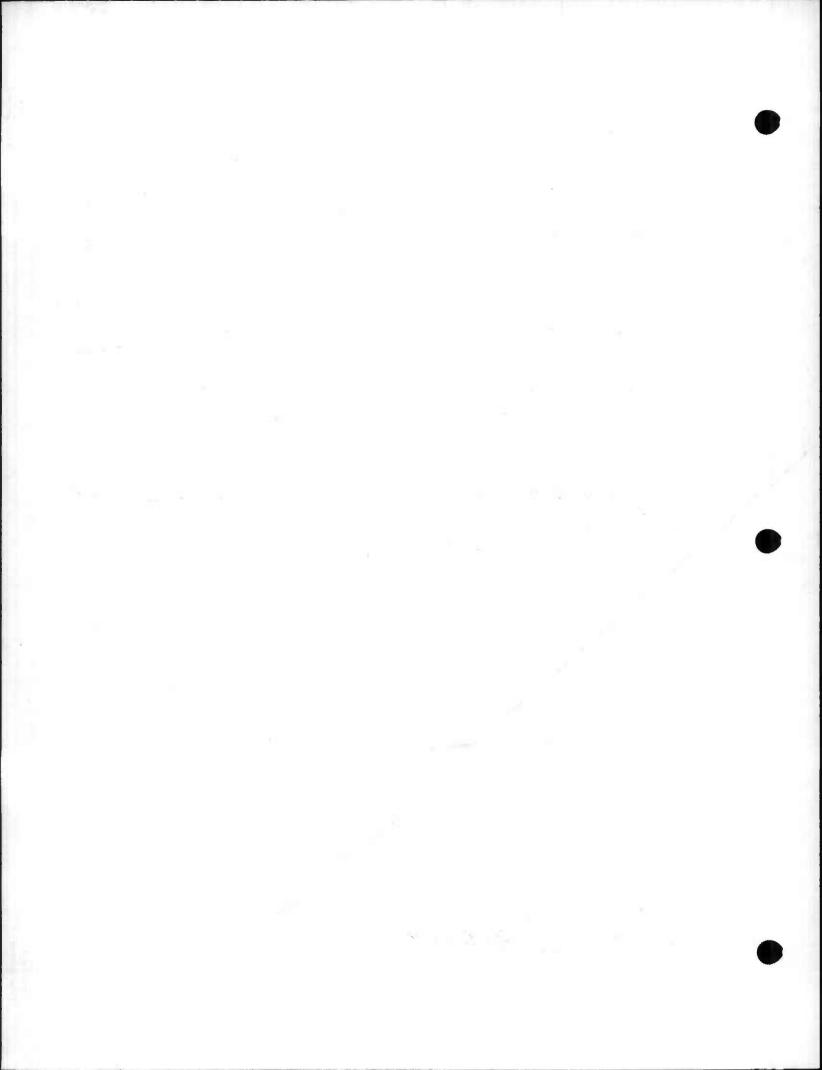
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT	AL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTH	AND MENT	AL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DA	TE OF DEATH	VEA	3. TIME OF DEATH
	Vanessa		H	lo1mes		ΰ5 ^{BAY} .	18 95	12:21 A _M
	The state of the s	5. SEX 8. AGE (1		F UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS	MIN. 7. DAT	E OF BIRTH rith, Day, Year)	_ Co	RTHPLACE (State or Foreign unitry)
	9a. FACILITY NAME (If not Institution, give stre			9b. CITY, TOWN OR LOCAT	101		COUNTY O	eryland F DEATH
DIRECTOR	Maryland Gener	al Hospita	1	Baltimo	re			NA
R	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION				10d. INSIDE CITY LIMITS?
	Maryland	NA		Balt	imore	City		1 TYES 2 NO
RAI	10e. STREET AND NUMBER			10f. ZIP COD		100	. CITIZEN O	F WNAT COUNTRY?
FUNERAL	35 S. Washingto:	n Street 12. WAS DECEDENT EVER IN	LUC ADMED		21231		US	
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	13. WAS DECENDENT	en, Mexicen, Puert	ilN? (Specify Yee or N o Rican, atc.)	8	ACE — American Indian, lack, White, atc.
BY	3 Wildowed 4 Divorced	TO TES, OIVE WAN ON DA	(123	1 TYES 2 XNO	Specify:		Sį	Black
	15. DECEDENT'S EDUCA (Specify only highest grade or	TION ompleted)	16e. OECEDENT'S U	SUAL OCCUPATION ork done during most of world	100	Sb. KIND OF BUSINES	S/INDUSTR	
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)				
once. COMPL	17. FATHER'S NAME (First, Middle, Last)	NA	Nu	rsing			ırsir	g
W	Howard Holmes					, Middle, Maiden Surna	ime)	
fled a	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING A	ADDRESS (Street and Number	lores		te Zin Codel	
Total	Annette Wright			Washingt				21231
ts P	20a METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remov	mi from State	PLACE AND DATE OF	DISPOSITION /Neme of	D.	TE 20c LOCATIO	N - City or	Town State
E	4 Donation 5 Other (Specify)	M	t. Zion	<u>Cemetery</u>	5/23	/95 Bal	timo	re, MD
e l	1 Deburled 2 Cremetton 3 Removal from State Cemetery, Cremetory or other place) Mt. Zion Cemetery 5/23/95 Baltimore 21. SIGNATURE OF FUNERAL SERVICE LIBERAGE 22. NAME AND ADDRESS OF FACILITY Unity Funeral Home							
еха	Dr.84	Lowell,	fo,			Avenue	Balt	o, MD 21201
traumatic event, the medical examiner must be notified ATION TO BE	23. PART I. Enter the disesses, or co shock, or heart fellure. Li	mplications that caused	the death. Do no	t enter the mode of dy	ing, such as ce	rdisc or respiretor	y srrest,	Approximate Interval Between
9	IMMEDIATE CAUSE (Finel							
T,	disease or condition Acquired Immunodeficiency Sundrome unknown Due to (or as a consequence of):							
20 -	Pancreatitis, Thrombocytopenia, Renal Failure unknown							
In a	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF)		r on a d			
E S	cause. Enter UNDERLYING CAUSE (Disease or Injury							ļ
other	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)					
5 E	d.							
를 실	PART II. Other significent conditions	contributing to deeth bu	ut not resulting in	the underlying cause	given in Part I.	24a. WAS AN AUTO PERFORMED		4b. WERE AUTOPSY FINDINGS
MEDIC						1 TES 2 XN		COMPLETION OF CAUSE OF DEATH?
								1 _ YES 2 _ NO
S Z	DID TOBACCO USE CONTRI				ERTAIN			
item	EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:				
≥	1 YES 2 NO 1	28e. OATE OF INJURY	28b. TIME	OF 28c, INJURY AT		ner (Specify) EŞCRIBE HOW INJUR	V OCCUBED	
5 C	1 Matural 5 Pending	(Month, Day, Yeer)	INJU	M 1 YES 2		LOONEDE HOW MOON	CCCORED	
28 is mar TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined detar						Il Route Number,	
E B	29e. CERTIFIER	AN. To the best of the second	,					
= =		AN: To the best of my knowle On the basis of exemination						e(a) end manner ee stated.
를 Ш	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LIC	ENSE NUMBER	, 29d	DATE SIGN	ED (Month, Day, Year)
	peorgia Cu, x		.D. 892			26 1/18/20		
F	30. NAME AND ADDRESS OF PERSON WHO							
	Georgia Cu, M	U C/O Mar	tyand (eneral Ho	spital			
	MAY 2 3 1995	3 A REGISTRARYS GOL	all.					

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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIFI	TMENT OF	HEALTH AND	MENTAL	HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1			2. DATE OF	F DEATN DAY	VEAD	3. TIME OF DEATN
		Robert	1 Hum	phrey	S		05	20	95	4:05P
P		312369/04	1 M 2 🗆 F	(in yrs. last birthdey) 56 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, 1	BIRTH Day, Year) 12 - 38	Count	PLACE (State or Foreign ry)
2, 3 should	СТОВ	99. FACILITY NAME (If not institution, give 8819 Ft. Small				on Location of D adena,	,			
Pages 1,	l W	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c. CITY	, TOWN OR LOCA	ATION				10d. INSIDE CITY LIMITS?
permit. P	AL DIR	Maryland A 100. STREET AND NUMBER	nne Arundel		Pasade	na M. ZIP CODE			TIZEN OF	1 ☐ YES 2 💢 NO
35	FUNERAL	8819 Ft. Smal				21122				S.A.
5-0020 nding physician. ss the burial-transit	ВҰ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAN OR C	IN U.S. ARMED 2 NO DATES	II yes, s	CENDENT OF NISPA pecify Cuben, Mexico S 2 NO Speci	an, Puerto Ric		14. RACI Blac Spec	E - American Indian, k, White, etc.
r afte	ETED	15. DECEDENT'S ED (Specify only highest grad	UCATION	16e. DECEDENT'S I (Give kind of w life. Do NOT use	ork done during m	ION ost of working	16b. K	IND OF BUSINESS/II	NDUSTRY	1
Spital of the control	COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Oil Burn	•	anic		Hein	s Bro	os.,Inc.
4 5 6 8 A		17. FATNER'S NAME (First, Middle, Last)						ldle, Malden Surname,		
	8	Joseph Howard 190. INFORMANT'S NAME (Type/Print)	Humphreys	10h MAII MO	ADDRESS (Dimet			Barnes City or Town, State, 2		
5 5 5	일	Florence Hum						sadena, Md		.22
MOKE,		20a, METHOD OF DISPOSITION t & Buriet 2 Cremation 3 Rer 4 Donation 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	noval from State 20	b. PLACE AND DATE O metery, crematory or oti	ner place)		DATE	20c. LOCATION		
W 64 m		21. SIGNATURE OF PONERAL SERVICE L	francisco .	rownsvill	22. NAME A	ND ADDRESS OF FA	CILITY		ville	Md.
BALTIN or death. Pag the funeral di vot.		> The leave V.	(Henry)	/		fully Fun		iome Pasaden	- Wa	21122
ted within-c4 hours are completely filled in by iai, cremation, or remove event, the medical		23. PART 1. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	d the deeth. Do no bach lina. Mach lina. A OPNSEOUENCE OF	ot enter the me	ode of dying, suc	ch as cardia	c or respiratory a	rrest,	Approximate Interval Betwee Onset and Deat
th certificate be executed by the certificate be executed by the certification and it hygiene prior to burn or other traumatic	DICAL CERTIFIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	A CONSEQUENCE OF						
ing the		PART II. Other significent condition	ns contributing to death t	but not resulting in	the underlyin	ig cause given in		4e. WAS AN AUTOPS PERFORMED?	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
sh of sh		DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YES	NO E	UNCERTAI	NU			1 YES 2 NO
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT						
the the	PHYS	1 ☑ YES 2 ☐ NO 27. MANUER OF DEATN	1 Inpatient 2 ER/Out	patient 3 DOA 26b. TIME	4 - Nursing Hon	ne 5 P Residence		Specify)	CCUIDED	
DING PHYS After this of death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	IRY WO	YES 2 NO	200. 02301	INC. NOW MOOK! O	COMED	
TTENDI TOR: A after d	ETED	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY building, etc. (Spe	" — At home, farm, st	reet, lactory, offic	ce ·		ON (Street end Numb Town, Stete)	er or Rural f	loute Number,
は対応目	COMPLE		SICIAN: To the best of my know ER: On the basic of examination) end manner as stated.
TO THE HOSPI TO THE FUNER De filed within	O BE (296. SIGNATURE AND TITLE OF CERTIFIE	20 Hy)			29c. LICENSE NUI	640	29d. DA	5/2	(Morth, Day, Year)
5+1		30. HAMI AND SOURCES OF PERSONAL	d drive	Acraden	a MD	21/22			1	A
		MAY 2 3 1995	32. REGISTRAR'S SIGN	ATURE						



BALTIMORE, MARYLAND 21215-0020

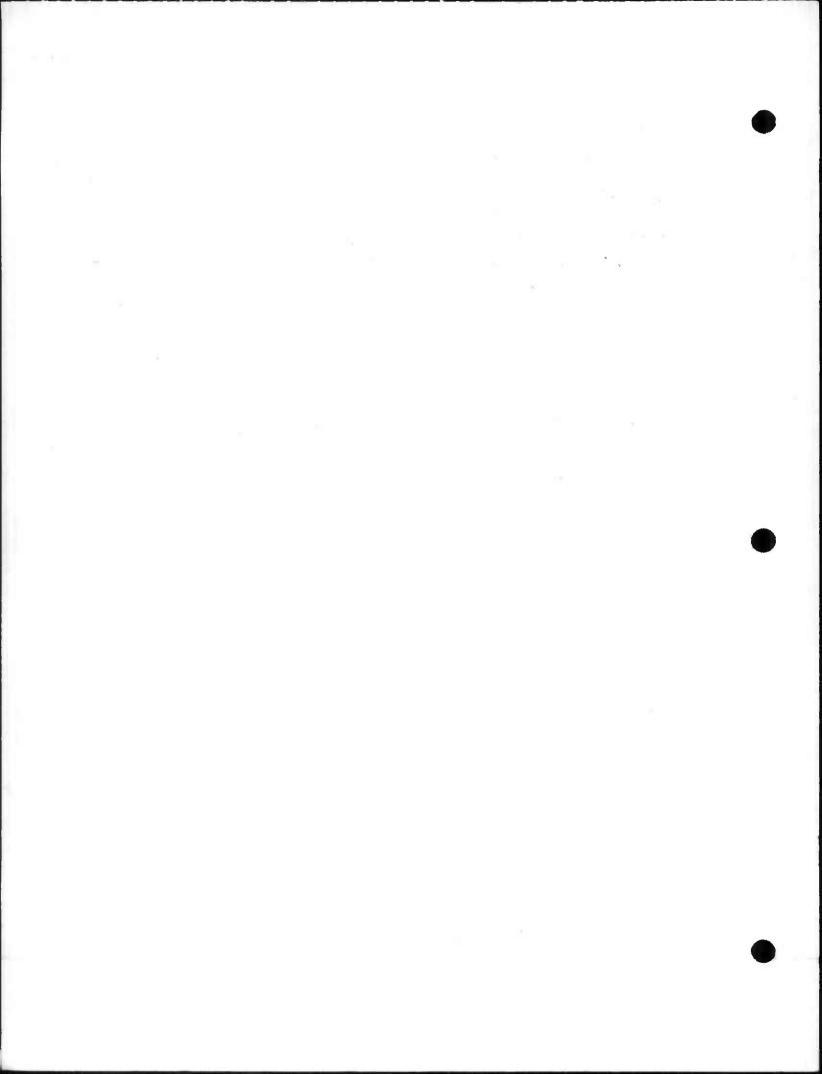
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an object of the Hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notitied at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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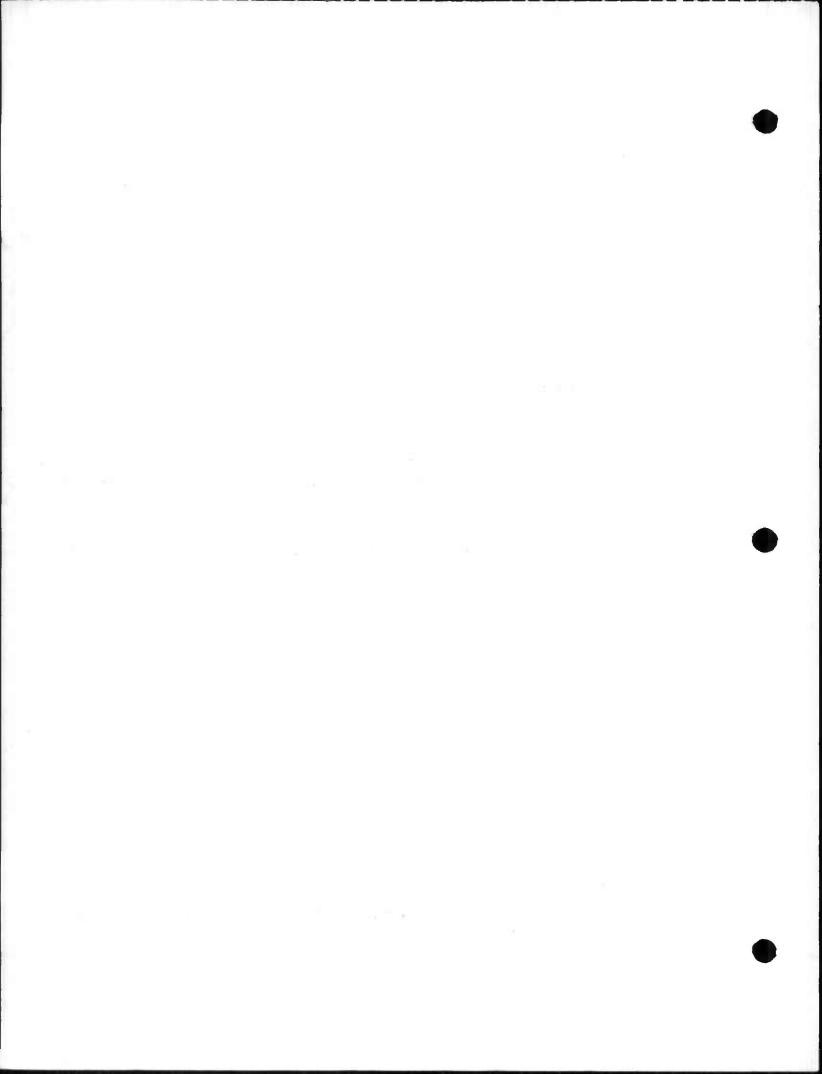
	1 - STATE REGISTRAR	STATE OF MARYLAND		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	(nn			-	AY YE	2 1 - 1	
DR.	4. SOCIAL SECURITY NUMBER 216-14-9327	5. SEX 6. AGE (In yrs.	yrs. IF UNDE	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0. E	NRTHPLACE (State or Foreign Country)	
	90. FACILITY NAME (IS, not institution, give s Bon Secour	treet and number) - Hospital	9b. CIT	y town or Location of D		9c. COUNTY	OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y. /	10c. CITY TOWN				10d. INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER	VIF	apt	101. ZIP CODE		100 CITIZEN	1 YES 2 □ NO OF WHAT COUNTRY?	
FUNERAL	740 Poplar	Grove St	11-R	2/2/	16	U	IST	
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED 13.	WAS DECENDENT OF HISPA If yes, specify Cuben, Mexico 1 YES 2 NO Specifi	an, Puerto Rican, etc.)	or No- 14.	RACE — American Indien, Black, White, etc. Specify:	
TED	15. DECEDENT'S EDU (Specify only highest grade	completed)	DECEDENT'S USUAL Of (Give kind of work done life. Do NOT use retired.)	during most of working	16b. KIND OF BU	SINESS/INDUST	RY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	enutica	1/marg.	Priva	te i	Industry	
BE CO	17. FATHER'S NAME (First, Middle, Leet)	Cole		Theo	AMERICFIRST, Middle, Maiden	lee		
10	Doris JAM	es	196. MAILING ADDRES 4320 (S (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Cod	21213	
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donetion 5 Other (Specify)	noval from State cometery.	CEAND DATE OF DISPO		5/0ATE 20c. LO	CATION - City	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC		2 - (501)	NAME AND ADDRESS OF FA	NOILITY 3	fine	ral Hone	
	Joseph 32 Battle Battle Battle	L. Puss	é	Razzw.	north	are-1	Balto, MI	
	23. PARTI . Enter the diseases, or shock, or heart fallura. IMMEDIATE CAUSE (Final	List only one cause on each i	ina.			iretory arrest,	Approximate Interval Batween Onset and Death	
	disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):						
NO	Sequentially list conditions to Primary undetermined							
CATI	oue to (or as a consequence or): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury							
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CON:	DUE TO (OR AS A CONSEQUENCE OF):					
	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS							
PHYSICIAN: MEDICAL					PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?	
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	28. PI HOSPITAL: 1 @ Inpatient 2 DER/Outpatient	OTHE	R:	- D			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK?			28d. DEŞCRIBE HOW INJURY OCCURED			
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, atc. (Specify)	M 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)			281. LOCATION (Street end Number or Rural Route Number, City or Town, State)		
COMPLETED	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee atsted.							
One) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the control of the control							use(e) end menner ee stated.	
8	296. SIGNATURE AND TITLE OF CERTIFIED	Tung-		29c. LICENSE NUI			NED (Month, Day, Year)	
T0	30. NAME AND ADDRESS OF PERSON WH	11 27						
	SAPAVILED (Norm (20 501) () DE RECISTRADE SIGNATURE							



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ROBERT JAMES HILL MAY 95 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1922 1 M 2 | F DAYS 240-568 MARC Pages 1, 2, 3 should 90. FACILITY NAME (If not institution, give 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH North Arundel RESIDENCE OF DECEDENT DIRECTOR pita ANNE-ARUNDE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 7 NO permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hyglene prior to burial, cremation, or removal, STIEMLY AVENUE 21060 S.A. Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married XX Merried is, specify Cuben, BY 1 TES 2 NO Specify Specify: 3 Widowed 4 Divorced WW II WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) BOX BUILDER N/A WESTINGHOUSE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOCTOR FRANK HILL BE LAURA WOODARD notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6 WILMER LOUELLA HILL 302 STIEMLY AVENUE, GLEN BURNIE, MD. 21060 9 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE 20c. LOCATION - City or Town, State tel Burlet 2 Cremetion 3 Ref 51/24/ cemetery, crematory or other piece) VETERANS CEMETERY ROWNSVILLE MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. SINGLETON FUNERAL HOME, SECOND AVENUE, S.W., GLEN BURNIE, MD. medical 23. PART I. Enter the diseases, or complications but caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or heart failure. List only the ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ erminal resulting in death) law requires that the death certificate be executed within traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Wee Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the any PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 - YES 2 NO has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The Item certificate h **EXAMINER?** HOOPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA HOSPITAL OR ATTENDING PHYSICIAN: " FUNERAL DIRECTOR: After this certifical within 72 hours after death with the Sta 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28c. INJURY AT WORK? this c 26e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural
2 Accident 1 YES 2 NO BY trivestigation 26e. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 26t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 28 Hem 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. FUNERAL (= 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE \$50g 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) **CHARLES** M.D. 1600 CRAIN HIGHWAY, GLEN BURNIE, MARYLAND 21061 WU 31. DATE FILED (Month, Day, Year) ,32. AEGISTRAR'S SCHATTERE

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m	after
	HOURS
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IA	The
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	PHYSICIAN:
ISION	IOSPITAL DR ATTENDING PHYSICIAN
2	DR A
	HOSPITAL

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH obet 95 Mensler 520 AMH May 7.0 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign May 27, 1938 DAYS HOURS MEN 216-32-0790 13€3¢M 2 □ F 56 YRS Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH n/a DIRECTOR Baltimore University Hospital RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a STATE 10h COUNTY 10d. INSIDE CITY Baltimore Middle River Md. 1 YES 2 1 NO permit. 10e STREET AND NUMBER FUNERAL 10f ZIP CODE 10a CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit IISA 223 Riverthorn Road 21220 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 K Married 1 TYES 2 X NO Specify: ВУ Specify: 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp. (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Board of Education 11th Baltimore County 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Harry Hensler Laura Coverston BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 223 Riverthorn Road Baltimore Md. 21220 Joan Hensler pe 20a. METHOD OF DISPOSITION
15 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Holly Hill Cemetery 5/23/\$5 Balitmore MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Connelly Funeral Home of Essex M the 300 Mace Ave. BAlitmore Md. removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: 1st only one cause on sech line. filled in by Approximate Interval Between 00 IMMEDIATE CAUSE (Finel **Onset and Death** the cremation, disease or condition resulting in daeth) Subwachnows Herentunge DUE TO (OR AS A CONSEQUENCE OF): completely 4 day event, to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, iseding to immediate physician prior ceuse. Enter UNDERLYING CAUSE (Diseese or Injury the attending phy Injury, or other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL signed by the shows any COMPLETION OF CAUSE 1 TES 2 1 - YES 2 NO peen has be Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATM (Check only one) State **EXAMINER?** certificate HOSPITAL: OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 TES 2 NO patient 2 ER/Outpatient 3 DOA o the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? this c 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY After death 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 49 8 Could not be DIRECTOR: A COMPLETED 4 Homicide 28 determined tem 1 DERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILES WITHIN 72 M 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) Par es So 7309 5/20/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALTMORE, M DZ1201 GREEN E ST. 22 5A101 5. 9 MAY 2 3 1995 3 REGLITARY , GN JU



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

BALTIMORE, MARYLAND 21215-0020

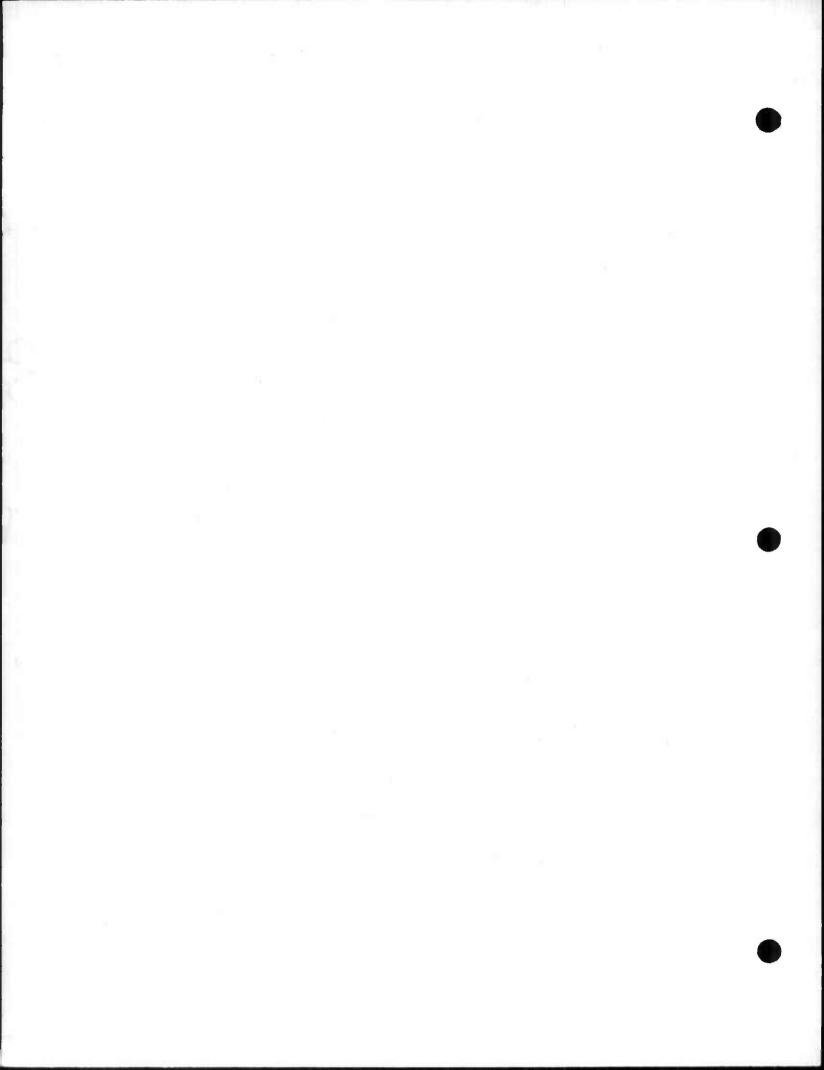
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE

REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. N	O.	
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATH		3. TIME OF OEATH
JAMES	THOMA	S	HARRI	SON		14 9!	AR 11:25A M
			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
4/1/NO WIN	1 📉 M 2 🗆 F	48 YRS. W	ONTHS DAYS	HOURS MHI.	APRIL 14, 1	CHE S	1ARVLAND
9a. FACILITY NAME (If not institution, give stree ALLEY OF 18 N. B.	et and number) ENTALOU STRE	ET	BAL	TIMORE	CITY	9c. COUNTY	
RESIDENCE OF DECEDENT						\sim	IA
10a. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCA	TION			10d. INSIDE CITY
MARYLAND	NA		BAL	TIMORE	CITY		1 X YES 2 NO
100. STREET AND NUMBER	OU STRE	ET	10	E. ZIP CODE	23		OF WHAT COUNTRY?
	12. WAS DECEDENT EVER #		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specity Y		RACE — American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		It yes, sp	ecity Cuban, Mexico 2 NO Specia	in, Puerto Rican, etc.)	2	Black, White, etc. Specify:
15. DECEDENT'S EOUCA	TION	16a. OECEDENT'S US	BUAL OCCUPATION	ON	16b, KIND OF B	USINESS/INDUST	A) C-A+ (C) C
(Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use r	k done during mo etired.)	ost of working			
11 TH GRADE	3511395 (14 01 34)	MAINT	ENAN	CF MA	V OFFIC	F BU	ILDINGS
17. FATHER'S NAME (First, Middle, Last)			-14/11/		ME (First, Middle, Maide		1-V/1VC7-3
JIM	VARP	ORDUGH	4	AMAN			eri-son
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	DDRESS (Street a	and Number or Rural	Route Number, City or To	wn, State, Zip Cod	0)
CAROLYN HARRISON & A.	MANDA HARRIS						4D, 2/223 or Town, State
20a. METHOD OF DISPOSITION 1 December 1 Dece	20b	PLACE AND DATE OF	DISPOSITION (N	arme of	DATE 20c, L	OCATION - City	or Town, State
4 Donation 5 Other (Specify)		etery, crematory or other	CEME	TERY	5-19-95 B		
21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME A	ND ADDRESS OF FA	CILITY		/
	4		1913 W	. BALTIMOR	N JR. FUNER E ST., BALTI	MORE, MD.	^A 21223
23. PART I. Enter the diseases, or co	mplications that caused	the deeth. Do not	enter the mo	de of dving suc	h sa cardiac or res	alretory erroet	Approximata
shock, or heart failure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ACUTE ALCOHOL 1						Intervel Batween Onset and Death
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST		CONSEQUENCE OF):					
PART II. Other significent conditions	contributing to death b	ut not recuiting in	the underlyin	g ceuse given in	Part I. 24s. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
					_ 7		1 YES 2 NO
DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIL	ч 🗆		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH					
¥Y⊒YES 2 □ NO	Inpetient 2 ER/Outp		THER: Nursing Hom	e 5 🗆 Residence	6X Other (Specify)	ALLEY	Y
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	285 TIME OF			28d. DESCRIBE HOW		
1 Netural 5 Pending 2 Accident Investigation	FOUND ON 5/14	/95 11:10			UNKNOWN		
3 Suicide 6 XX Could not be	28e. PLACE OF INJURY building, etc. (Spec	- At home, farm, stre-	et, factory, offic		28t, LOCATION (Street City or Town, State		
4 Homicide determined		FOUND IN AL	LEY		Dat Trunna	7 18 N. B	ENTALOU ST.
	AN: To the best of my knowl	edga, daath occurred a	at the time, date				
2 X MEDICAL EXAMINER:	on the basis of examination	and/or investigation, i	n my opinion, d	eath occured at the	time, data and place, a	nd due to the cau	use(s) and manner as stated.
29b. SIGNATURE AND TATLE OF CERTIFIER	11/1			29c. LICENSE NUI			NED (Month, Day, Year)
	Mar			O.C.M	I.E.	► MA	AY 15/95
30. NAME AND ADDRESS OF PERSON WHO				ET. BAI	TIMORE.	MARYI	AND 21201
31. DATE EILED (Mogin, Day (OE)	32 DEGISTRAR'S GN	TURE		,			
MAY 2 3 1995 Jul	A SIMPLEMENT OF	all.					



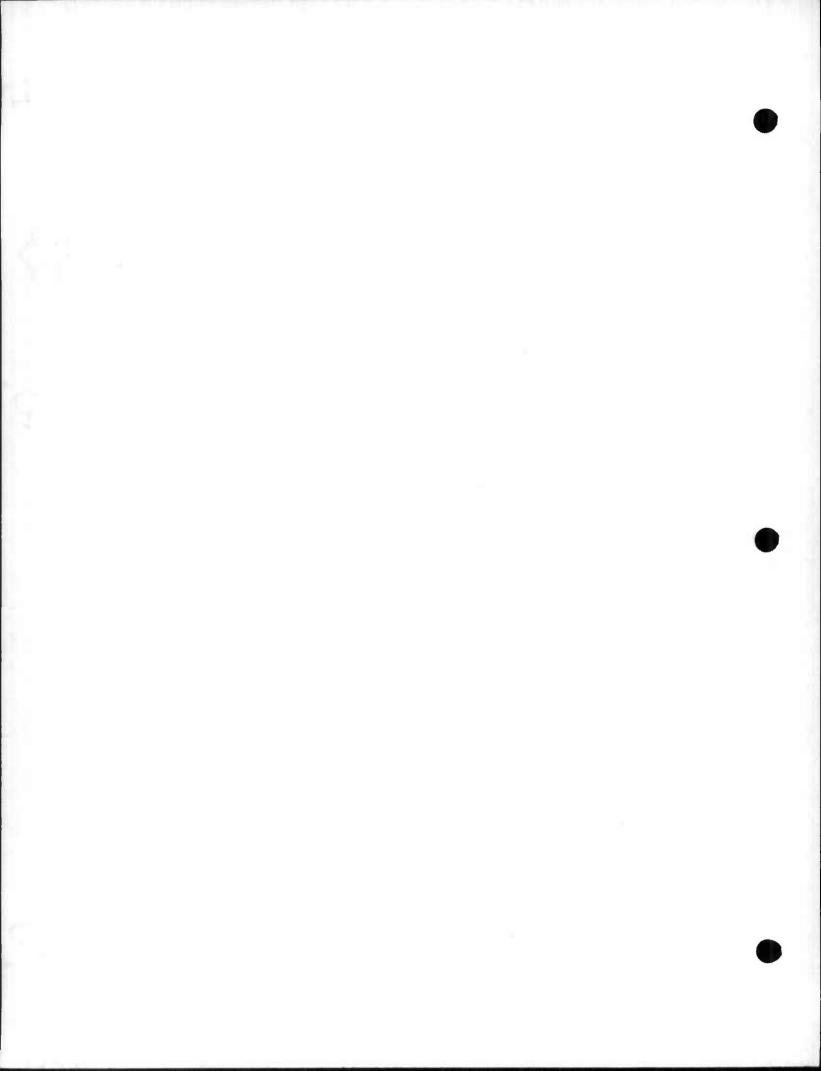
BALTIMORE, MARYLAND 21215-0020	ath certificate be executed within exthours after death. Page 6 may be retained by the hospital or attending physician.	Itending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should all known and the hund representation or semical.
B/8	hours after d	ed in by the
P.O. BOX 68760	ath certificate be executed within at	tending physician and completely filled in by the

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the Vibrance float that the first scrifficate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

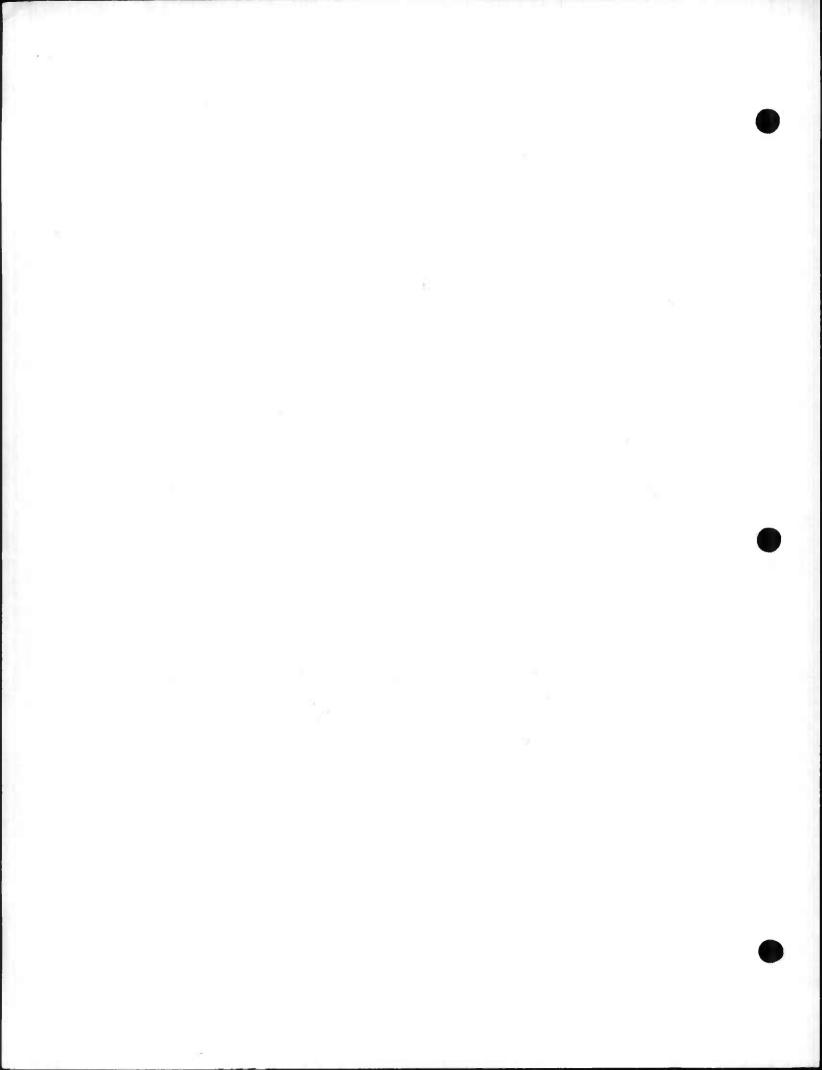
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE STATE OF MARYLAND / DEI	PARTMENT OF I	EALTH AND M	IENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
	Gladys Knox Houck		ĺ	May 20	1995	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthe		IF UNDER 24 HRS.	7. DATE OF BIRTH	8. B	IRTHPLACE (State or Foreign
	214-36-9726 1 M 2 T 95 YF	RS. MONTHS DAYS		April 9, 19	00 M	aryland
æ	129 Liberty Road		OR LOCATION OF DEA	TH	9c. COUNTY C	
DIRECTOR	RESIDENCE OF DECEDENT	Syl	esville		Carro	11 County
R		CITY, TOWN OR LOCA	ION			10d. INSIDE CITY LIMITS?
	Maryland Carroll County	Sykesy				1 TES 2 NO
RA	10e. STREET AND NUMBER 129 Liberty Road	10	. ZIP CODE			OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	1 20 1110 000	21784		U.S.	
BY FU	1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 1 Yes 2 No IF YES, GIVE WAR OR DATES	If yea, ap	ecify Cuban, Maxican, 2 NO Specify:	C ORIGIN? (Specify Yes, Puerto Rican, etc.)		ACE — American Indian, Nack, White, etc. Specify: White
	15. DECEDENT'S EDUCATION 16e. DECEDE	NT'S USUAL OCCUPATION	ON	16b. KIND OF BUS	I SINESS/INDUSTR	
COMPLETED	(Specify only highest grade completed) (Give kin Elementary/Secondary (0-12) College (1-4 or 5+)	d of work done during mo OT use retired.)	st of working			
MP	2	Teacher		Elemen	tary E	ducation
8	17. FATHER'S NAME (First, Middle, Last)			E (First, Middle, Maiden		
BE	George B. Knox			le V. Ma		
2		LING ADDRESS (Street o				·
	20a. METHOD OF DISPOSITION 20b BLACE AND D	9 Liberty ATEOFDISPOSITION/N		DATE 20c. LO		
	1 🔀 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	easant Cem	etery 5/			Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME A	ID ADDRESS OF FACI	LITY		
	* Whing of Alexant			L HOME (P		
\neg	23. PART i. Enter the diseases, or complications that coused the deeth.	Do not enter the mo	esville.	MD 21784	(410)-7	795-1400 Approximata
	ehock, or heart failure. List only one cause on sech line. IMMEDIATE CAUSE (Final		, , , , , , , , , , , , , , , , , , , ,			interval Between Onset and Death
	disease or condition pauling in death) Dementia, Mi	ulti infar	ct type			Years
	DUE TO (OR AS A CONSEQUENCE					Tears
8	Sequentially list conditions, b. Breast Mass					
CERTIFICATION	ir any, leading to immediate					
윤	CAUSE (Disease or injury that initiated events Due to (OR AS A CONSEQUENCE	Heart rall CEOF):	ure			
EH	resulting in deeth) LAST Pneumonia					
	PART II. Other algorificent conditions contributing to deeth but not result	ing in the underlyin	cause given in P	art i. 24e. WAS AN	ALITOREY	24b. WERE AUTOPSY FINDINGS
CAL		and the enderlyne	g cause given in F	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
				1 YES 2	X) NO	OF DEATH?
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES T NO K	LUNCERTAIN			1 TES 2 NO
NA I	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF	DEATH (Check only one)				
)S	1 YES 2 XNO HOSPITAL: 1 Inpetiant 2 ER/Outpetient 3 Do	OTHER:	• 5 X Residence 6	Other (Specify)		
Y PHYSICIAN: MEDIC	1 Netural 5 Pending (Month, Day, Year)		URY AT RK?	28d. DESCRIBE HOW II	NJURY OCCURED	
D BY	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, fe			281. LOCATION (Street a	and Number or Rui	ral Route Number,
	4 Homicide determined building, etc. (Specify)			City or Town, State)		
COMPLETED	29e. CERTIFIER (Check only (Ch	curred at the time, date	end place, and due to	the cause(e) and man	ner se stated.	
Š	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation					se(s) and manner as stated.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMB	ER	29d. DATE SIGN	NED (Month, Day, Year)
2 2	11/1/1/501		D33681		► May	22, 1995
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (
	M.K. McEvoy, M.D. 7590 College Ave	nue, Syke	sville, M	D 21784		
ام	MAY 2 3 1995 Juli olumber Real &					100
	The state of the s					DUM 10 Pay 1/80



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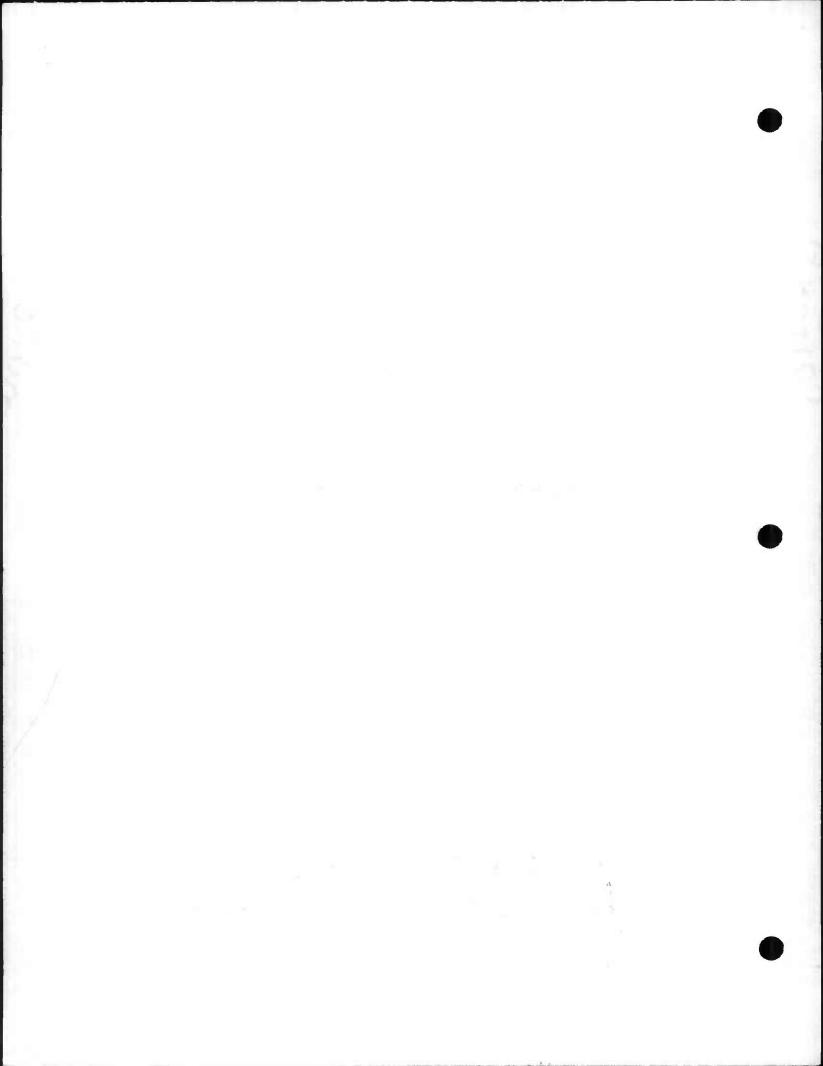
		1 - FOR STATE OF MARYLAND / DEP. CERT	ARTMENT OF HEALTH AND IFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) Edward 5. Hutton 1. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (b) up lost bishold		2. DATE OF DEATH DAY	96 01:31 AM
9		216 05 2994 1 M 2 D F 89 YRS	MONTHS DAVE MOURS ANN	7. DATE OF BIRTH (Month, Day, Year) SEPT 5 1905	BIRTNPLACE (State or Foreign Country) MARYLAND
2, 3 should	O.B.	99. FACILITY NAME (If not inetitution, give eireet end number) CARROLL COUNTY GENERAL HOSPITAL	96. CITY, TOWN OR LOCATION OF D WESTMINSTER		UNTY OF DEATH ARROLL
- -	DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c.	CITY, TOWN OR LOCATION		10d. INSIDE CITY
permit. Pages		MARYLAND CARROLL	SYKESVILLE		1 YES 2 B NO
Isit	FUNERAL	100. STREET AND NUMBER 7200 3RD AVENUE	101. ZIP CODE 21784	111	J.S.A.
21215-0020 al or attending physician. for use as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPA If yes, specify Cuben, Mexic 1 YES 2 NO Spec	NNIC ORIGIN? (Specify Yee or No—	
r attend	윤	(Specify only highest grade completed) (Give kind	T'S USUAL OCCUPATION of work done during moet of working	16b. KIND OF BUSINESS/IR	IDUSTRY
	OMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) EXECUT	TUSE retired.)	PRINTING	
2 2 -	111 05	17. FATNER'S NAME (First, Middle, Last) EDWARD S. HUTTON	LULU		
S 5 0	1 1		NG AODRESS (Street and Number or Rural AY PASTURE COURT		
BALTIMORE, I er death. Page 6 may be the funeral director, page val.	must be	20e. METHOO OF DISPOSITION 1	TEOF DISPOSITION (Name of		City or Town, State
ALTIMO death. Page 6 funeral directo	medicai examiner	21. SIGNATURE OF FUNESTAL SERVICE SUCENBEE	LEROY & RUSSE	CL WITZKE FUNEI	RAL HOME
BA rs after dean n by the fur	caj exa	23. PART i. Enter the diseases, or complications that caused the death. D		N AVE BALTO. MI	
hirt 24 hours tely filled in mation, or n	event, the medi	ahock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE	1 - 0		Approximata interval Between Onset and Dasth
P 8 6 7		Sequentially list conditions Th. Ventricular	e Tach veard	ica	Iweek
SOX ite be exprision a	CATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	fficiency		
P.O. h certifi anding p Hygien	ry, or other traumatic	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE	OF):		
RECORDS, P requires that the death been signed by the atter t. of Health and Mental is	7 1	PART II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in	Part I. 24e. WAS AN AUTOPSY PERFORMED?	
	shows any inju	Dementia, Pulmonary 1-1, Atrial Fibrillation Fracture	brasis	1 YES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL RECOF he law requires tha has been signed bet, of Health a			YES NO DE UNCERTAL		1 TYES 2 NO
F VITAL I SICIAN: The law certificate has be the State Dept.	Item SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Anpettent 2 ER/Outpetient 3 DOA	EATH (Check only one) OTHER: 4 □ Nursing Home 5 □ Residence	S C Other (County)	
O 뜻 북불		27. MANNER OF DEATN 1 Naturel 5 Pending 28e. DATE OF INJURY (Month, Day, Year) 28b. 1	TIME OF INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OF	CURED
DIVISION OR ATTENDING I DIRECTOR: After hours after death	2 D	2 Accident Investigation 3 Suicide 6 Could not be datermined 28e. PLACE OF INJURY — At home, ferr building, etc. (Specify)		26f. LOCATION (Street and Number City or Town, State)	er or Rural Route Number,
DIVISI AL OR ATTEN AL DIRECTOR: 2 hours after	ЕШ	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurrence one)			
HOSPITAL FUNERAL within 72 h	CO	2 MEDICAL EXAMINER: On the beele of examination end/or investige 29b. SIGNATURE AND TIPES OF CERTIFY	ation, in my opinion, death occured at the		
TO THE DE fled	IMPOR TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEMAN) (7)	D341	24 1	Max 20, 1995
8		GOHND MILTOMD 7600 USI	er) (#311	Towson, ma	12,204
		MAY 2 3 1995 Julia Studies (1997)			



ITEMS: 23 PART I. 27. 28a-f. PER MEO FILM 6-724 6/5/95 + +

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

77	1 - STATE REGISTRAR	STATE OF MARY	CERTIF	TIMENT OF I	DEATH AND	MENTAL HYGII REG. I				
į.	1. DECEDENT'S NAME (First, Middle, Lest JANE)		HOE	FTMAN	2. DATE OF DEATH		95	3. TIME OF DEATH 5:48P	M
	4. SOCIAL SECURITY NUMBER	1 M 2 X F	iE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year, August 9	32	8. BIRTH Country	PLACE (State or Foreign	
20	90. FACILITY NAME (If not institution, give 2138 ALICE A)3		OR LOCATION OF D	DEATH		NTY OF DI	E GEORGES	3
DIRECTO	10a. STATE 10b. COUN	nce Georges		xen Hill					10d. IHSIDE CITY LIMITS? 1 YES 2 HO	
FUNERAL	100. STREET AHD HUMBER 2138 Alice Ave.	# 103		10	1. ZIP CODE 20745	-	10g. CIT	IZEN OF W	HAT COUNTRY?	_
2	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	S 2 NO	If yes, sp	CEHDENT OF HISPA secify Cuben, Mexic 3 2 HO Spec	NIC ORIGIN? (Specify can, Puerto Rican, etc.) //y:	Yes or Ho—		- American Indien, White, atc. y: White	
	15. DECEDEHT'S ED (Specify only highest grad Elementary/Secondary (0-12)		tee. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION work done during mose retired.)	ON ost of working	16b. KIND OF	BUSINESS/INC	DUSTRY		
	17. FATHER'S NAME (First, Middle, Lest)				16. MOTHER'S H	AME (First, Middle, Meid	den Sumeme)			
	19e. INFORMANT'S HAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rurel	Route Number, City or	Town, State, Zip	Code)		
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Red 4 Dopartion 5 Other (Specify)	moval from State	tob. PLACE AHD DATE semelery, crematory or c	ther place)			LOCATION —			
	man All	Ronald	Wade, Dir		ND ADDRESS OF F	ACILITY State nore St.,	Anator Balto	my Bo	ard 21201	
	27 PAHT I. Enter/the diseases, or shock, or heert feilure MMEDIATE CAUSE (Finel disease or condition resulting in death)	NORTRIPTYL	INE INTOXIC	ATION	ode of dying, su	ch as cerdlec or re	spiratory an	rest,	Approximate interval Betwee Onset and Da	
	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that intileted events resulting in death) LAST	c	S A CONSEQUENCE O							_
	PART II. Other significent condition	ons contributing to deeth	but not resulting	in the underlyin	g csuse given in	PERF	AN AUTOPSY ORMED? 2 HO	24b.	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MIN. IN	DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE	OF DEATH YI		UNCERTAI	N 🗆			1 YES 2 NO	
PHYSICIAN:	EXAMINER? 1 X XES 2 HO 27. MANNER OF DEATH	HOSPITAL: 1 inpatient 2 inpati	utpetient 3 DOA	OTHER: 4 Nursing Hom		6 Other (Specify) 28d. DESCRIBE HON	W IN HIRDY OC	CURED		
B	1 Hatural 5 Pending 2 Accident Investigation 3)(1) Suicide 5 Could not be	FOUND: 5-2-	95 5:48	PM 1	YES X 1 HO	SUBJECT INC	SESTED C	DRUGS		
LETED	4 Homicide determined	building, atc. (S	FOUND:	HOME		281. LOCATION (Stree City or Town, Sta OXON HILL,	MARYLA	ND	AVENDE	
COMPLET	(Check only 1 L CERTIFYING PHY	SICIAH: To the best of my knoter: On the beste of examinar							end menner es stated.	
TO BE	296. SIGNATURE IND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W	U. King	ing		O . C . M		29d. DAT	E SIGHED ((Month, Day, Year) 03/95	
	THEO PORE N 31. DATE FILED (Month, Day, Year)	U	111 PENN		BALTIMO	RE, MARYL	AND 21	1201		
	MAY 2 3 1995		Rodall							



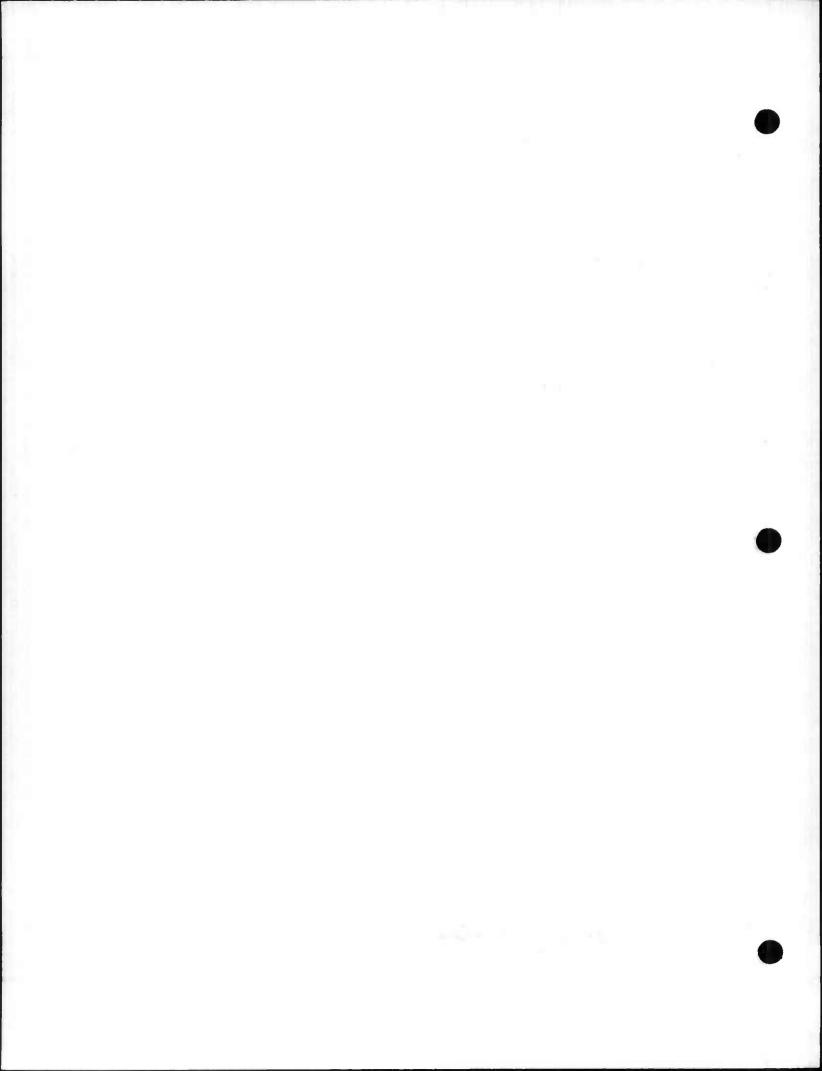
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memai Hyglene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

						95	15/23
	FOR 1 . STATE	STATE OF MARYLAND			MENTAL HYGIEN	ΙE	
	REGISTRAR	CI	ERTIFICAT	E OF DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)	2.1			2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
	Elwood Milton	1 Johnson			May 21	199	5 9:04 am
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. las	st birthday) IF UND	ER 1 YEAR IF UNDER 24 HRS.	Z DATE OF BIRTH	7	HPLACE (State or Foreign
	215-20-25251	1 M 2 D F 72	YRS. MONTHS	DAYS HOURS MIN.	(Month, Day,)(sar)		try)
	9a. FACILITY NAME (If not institution, give sti	reet and number)	Oh CIT	Y, TOWN OR LOCATION OF D	MU9. 24		arylana
Œ	Kent and Queer			hestertown		9c. COUNTY OF	DEATH /
5	RESIDENCE OF DECEDENT	1 villes 1103h1	cal c	THE STEEL TOWN	MD	Kent	
E C	100 STATE 1 10b. COUNTY		toc. CITY, TOWN	OR LOCATION			10d. INSIDE CITY
DIRECTOR	Maryland K	ont	Cho	sterton	110		LIMITS?
	10e. STREET AND NUMBER		LITE	10f, ZIP CODE	(1)	L to - OTTEN OF	WHAT COUNTRY?
E.	710 Hinh	St		IUI, ZIF GODE		ING. CITIZEN OF	WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	211				I U	
3	1 Never Married 2 Married	12. WAS DECEDENT EYER IN U.S. AR FORCES? 1 VES 2	MED 13	. WAS DECENDENT OF HISPA If yes, specify Cultur, Maxic	NIC ORIGIN? (Specify Yes		E — American Indian, ck, White, etc.
ВУ	3 Wildowed 4 Divorced	YES, GIVE WAR OR DATES -	TT	1 TES 2 NO Speci	fy:	A Cape	chy:
	15. DECEDENT'S EDUC	vvoria vvar	<u> </u>			VITTI	can Amer.
Щ	(Specify only highest grade of	completed) (G	CEDENT'S USUAL	during most of working	16b. KIND OF BU	SINESS/INDUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Do NOT use retired.	7	1 2	~ -	
COMPLETED			IUCD	Driver	Ta	lm	
8	17. FATHER'S NAME (First, Middle, Last)	I TI	20	18. MOTHER'S NA	AME (First, Middle, Maideo	Surname)	1.1
BE	John Doug	1as John	Son	IMar	V Hall	16 Da	halaar.
5	19a, INFORMANT'S NAME (Type/Print)	199	b. MAILINO ADDRES	SS (Street and Number or Rural	Noute Number, City or Tow	n, State, Zip Code)	
_	Elva Mc Dan	16 8	213 AL	verill (t	Severr	1.1VId. 2	21144
	20a METHOD OF DISPOSITION 1 W Burlet 2 Cremation 3 Ramo		AND DATE OF DISPO		DATE 20c. LO	CATION City or T	own, State
	4 Donation 6 Other (Specify)	vat trom State	a a the place	vav Chan	5/27/95 1	Broady	neck Nd.
	21. SIGNATURE OF FUNERAL SERVICE LICE	MSEE D D			ICILITY	100	11
	► hinh	TRIL	11/2	oseph Lit	russ, ru	nera	Home
	23. PART/I/ Enter the diseases, or co	provilegations that caused the de	Do not only	add W. NO	rth Ave	Balte	0,110,21216
	shock, or heart failure. L	ist only one cause on each line		r the mode of dying, suc	on all cardiac or respi	ratory arrest,	Approximats interval Between
- 1	iMMEDIATE CAUSE (Final disease or condition	0 1		m			Onset and Death
	resulting in death)	Dessoching	More	ac Cent	a Cener	enjam	
		DUE TO (OR AS A COMSEC	DUENCE OF):				
N	Sequentially list conditions,						
Ĕ	if any, leading to immediate	DUE TO (OR AS A CONSEC	DUENCE OF):				
ERTIFICATION	CAUSE (Disease or injury						
쁜	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):				
H	descring in death, EAST						
0	PART II. Other significent conditions	contributing to death but not r	esulting in the u	indestylna ceuce olum in	Boot I or uno au	ALTTONON LAW	
MEDICAL	OP of Dai	1. 0 (2) k/-	7	indertying couse given in	Part I. 24a, WAS AN PERFOR		AWAILABLE PRIOR TO
ā	Office Jan	une G (7-9/)	neus	con	1 YES 2	NO	OMPLETION OF CAUSE OF DEATH?
×	3 Chome on	dural Henry	700-0	& asothung	E Synn	Sorle	1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEA	TH YES	NO UNCERTAI	N 🗆 🗸		
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC HOSPITAL:	E OF DEATH (Check				
S		t inpatient 2 - ER/Outpatient 3	DOA 4 Nu	R: rsing Home 5 ☐ Residence	8 Other (Specify)		
1	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW I	NJURY OCCURED	
ВУР	1 Natural 5 Pending	(MONN, Day, real)	INJURY M	WORK?			
0 8	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY - At ho	me, farm, atreet, fac	ctory, office	281. LOCATION (Street a	and Number or Rural	Boute Number
ш	4 Homicide detarmined	building, atc. (Specify)			City or Town, State)		
	29a. CERTIFIER						
COMPL	(Check only	IAN: To the best of my knowledge, de					
Ö	2 MEDICAL EXAMINER	On the basis of examination and/or i	nvestigation, in my	opinion, death occured at the	time, data and placa, an	d dua to the cause(e) and manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER	29d. DATE SIGNED	(Month, Day, Year)
0	164. When	, KID.		021	3/3	D.C/22	195
U 1	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEL	4 070 (Terry Defent				
2	The state of the s	COM TRIES GROOF OF OFWILL BILL	u 21) (type, Phili)				
	KIN K. WO	IN, 216	4-96 S	Fr, Chest	o la	MD	21620



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7		1 - STATE STATE REGISTRAR	OF MARYLAND /	DEPARTMENT OF ERTIFICATE OF	HEALTH AND MEI	NTAL HYGIENE REG. NO.	
		000/ 1000	E. JOA	JES, JR.	MD	DATE OF DEATH DAY	3. TIME OF DEATH
p		4. SOCIAL SECURITY NUMBER 5. SEX 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		YRS. MONTHS DAYS	HOURS MIN. 1	DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country) North Carolin
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street and num 26 Hobart Court	ber)		or location of death 11stown	9c. C0	Baltimore
Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOC			10d. INSIDE CITY
it permit.		Maryland Baltimor	<u> </u>	Randall	Of. ZIP CODE	10g. C	1 YES 2 NO
burial-transit permit, Pages 1,	FUNERAL	1 Never Married 2 K Merried FORCE	CEDENT EVER IN U.S. AF	NO If yes, s	pecify Cuban, Mexican, Pu	ORIGIN? (Specify Yes or No-	U.S.A. 14. RACE — American Indian, Black, White, etc.
as the	ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION	GIVE WAR OR DATES	1 - YE	S 2 🐧 NO Specify:	16b. KIND OF BUSINESS/I	Specify: White
ed for u	COMPLET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1- Medical	4 or 5+)	ive kind of work done during in Do NOT use retired.) Physician		The state of the s	c Surgeon &
be detach at once.		17. FATHER'S NAME (First, Middle, Last)				First, Middle, Malden Sumame	
should	TO BE	Wayland E. Jones, Sr. 190. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADDRESS (Street		Number, City or Town, State,	Zip Code)
page 5	-	Mrs. Edith Jones 20a. METHOD OF DISPOSITION	20h PLACE	26 Hobart C		111stown, MD	21133 — City or Town, State
funeral director, page xaminer must be		1 Buriel 2 X Cremation 3 Removel from St 4 Donation 5 Other (Specify)	cemetery, cre Carro	retory or other plece) LI Cremation	Service 5/	20/95 Hampst	ead, Maryland
s funeral di L examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME /	AND ADDRESS OF FACILIT	v eral Directo	
nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. by other traumatic event, the medical or	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	UE TO (OR AS A CONSE	DUENCE OF): DEL FERS 1 DUENCE OF):	Failur		Approximate interval Betwee Onset and Dae
as been signed by the attend bept, of Health and Mental Hy 23 shows any injury, or	MEDICAL CE	PART N. Other significant conditions contributed and the contribut	Metas to	Canal Canal	tute VUNCERTAIN [PERFORMED?	Y 24b. WERE AUTOPBY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
rtificate h he State [or item	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 1 Inpette		CE DF DEATH (Check only one OTHER: 4 □ Nursing Ho	me 5.P. Reeldence 6 🗆	Other (Specify)	
this ce with ti	ВУ РН		ATE OF INJURY onth, Day, Year)	INJURY W	JURY AT 28d ORK? YES 2 NO	1. DESCRIBE HOW INJURY O	CCURED
after d	0	3 Suicide 6 Could not be 4 Homicide datermined	ACE DF INJURY — At ho ilding, atc. (Specify)	me, farm, street, fectory, off	ce 261.	. LOCATION (Street end Numb City or Town, State)	per or Rural Route Number,
-101	COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the CERTIFYING PHYSICIAN: To the Details on the Deta					
TO THE FUNERA be filed within 72 IMPORTANT: II	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER AND TITLE OF CERTIFIER AND ADDRESS OF PERSON WHO COMPLETE	MA D. CAUSE OF DEATH ATE	M 27) /Sino Print!	29c. LICENSE NUMBER	29d. D/	ATE SIGNED (Month, Day, Year)
1		My Hyner Copeland MD 31. DATE FILED (MONTH, Day, War) 32. RE		Court Road	Ente 201 Range	dallstaw MD	21133
·		MAY 23 1995	· · · · · · · · · · · · · · · · · · ·	1.11			

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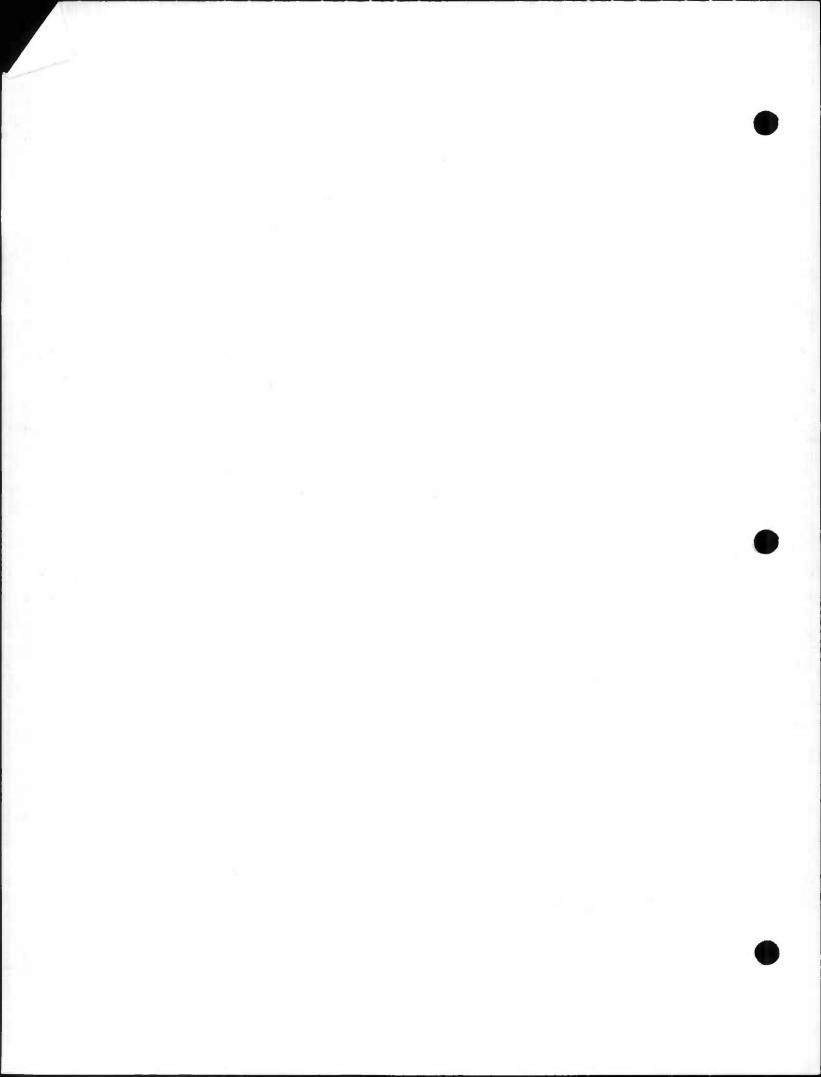
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+	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hospital or attending physician.	vician,
1	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pag	al-transit permit. Pag
	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	
	The second secon	

MAY 2 3 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Lest) 2. DATE OF DEATH 3. TIME OF DEATH nie DNPS mal 1055 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday, 7. DATE OF BIRTH (Month, Day, Year) JULY 31 1918 IF UNDER 1 YEAR B. BIRTHPLACE (State or Foreign 05-DAYS HOURS 1 X M 2 F 76 VA 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MERCY HOSPITAL DIRECTOR BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A BALTIMORE CITY 1 X XES 2 NO FUNERAL 104. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1617 E. 30TH STREET 21218 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? t YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, afc. 1 Never Married 2 Married В 1 TYES 2 NO Specify: Specify: Widowed 4 Divorced WWII BLACK 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) STEEL WORKER BETHLEHEM STEEL CORP. N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ ELISAH JONES ELIZABETH B JACKSON notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CURTIS JONES 1617 30TH ST. BALTIMORE, MD. 21218 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must MBurial 2 Cremation 3 Removal from State □ Donation 5 □ Other (Specify) BALTIMORE CEMETERY 5/22 BALTIMORE. MD 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1129 N. CAROLINE ST. BALTO., MD21213 medical 23. PART I Effor the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart fellure. List only one cause on each line. Approximate intervai Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition_ Respiratori resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): WOSE CERTIFICATION traumatic Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS pertension PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO T YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Minpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO 8 Other (Specify) 4 Nursing Home 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural BY 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 200 4 Homicide 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, data and place, and due to the cause(s) and man (Check only one) MPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE P 0817 17, 1995 0 ME OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



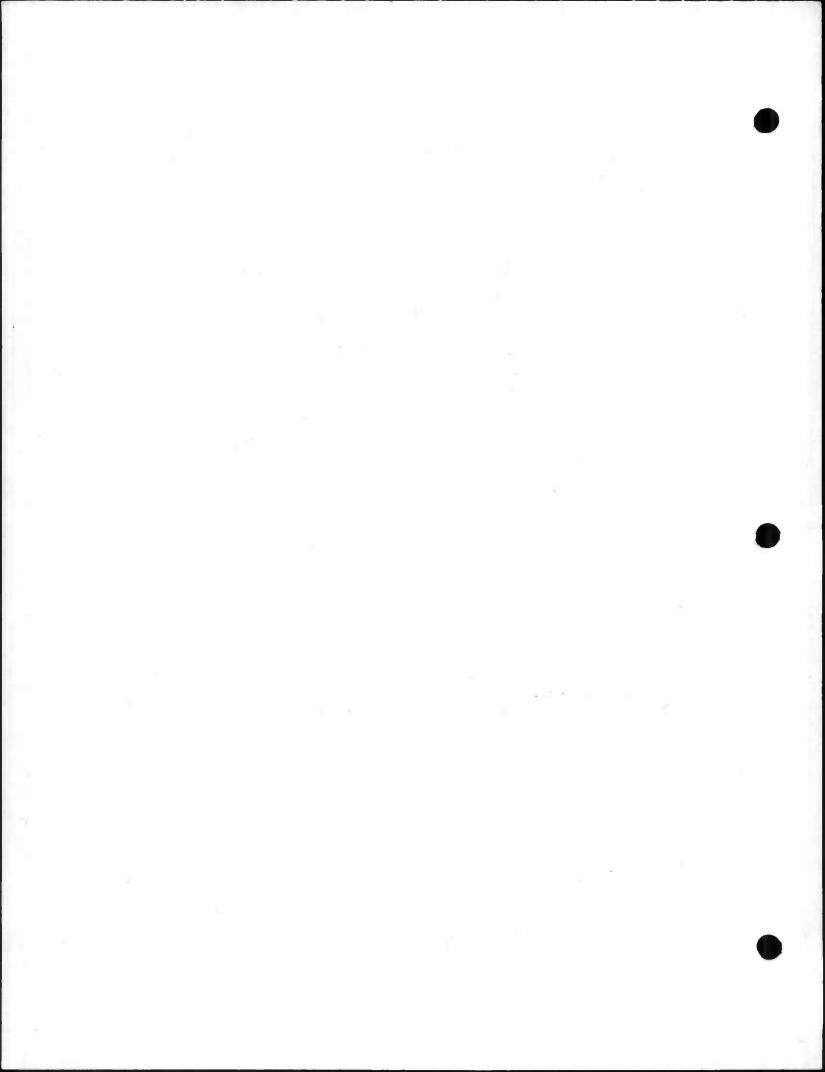
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an oversite death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.										
	1. DECEDENT'S NAME (First, Middle, Last)	houn		P - 1 A	EAR 3. TIME OF DEATH						
	4. SOCIAL SECURITY NOMBER 5. S 2/2-20-2362	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)								
	9a. FACILITY NAME (If not-institution, give street a	nd number) 9b. CIT	Y, TOWN OR LOCATION OF DEAT	1-22-16 TH 8c. COUNTY	OF DEATH						
CTOR	RESIDENCE OF DECEDENT HOSPITA BOLLIMORE MA										
DIRECTOR	Marylam 106. COUNTY	10c. CITY, TOWN	Baltimore		10d. INSIDE CITY LIMITS?						
RAL	10e. STREET AND NUMBER	Amenine	10f. ZIP CODE	16 log. CITIZEN	OF WHAT COUNTRY?						
FUNERAL	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S. ARMED 13.	. WAS DECENDENT OF HISPANIC If yes, specify Cyban, Maxican,	ORIGIN? (Specify Yes or No- 14.	. RACE — American Indian, Black, White, atc.						
D BY	3 Widowed 4 Divorced	F YES, GIVE WAR OR DATES	1 VES 2 NO Specify:		Back						
COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Spanndary (0-12) Col		during most of working	16b. KIND OF BUSINESS/INDUS	TRY						
OMPI	17. FATHER'S NAME (First, Middle, Last)	O Domes	18. MOTHER'S NAME	OWN HON	ne						
BE C	Walter G.	Snowden	louis	e Rhueb	sottom						
임	ANTHON (Sno	wen 711 W	is speet and Number or Rural Roll Llown a've	uto Number City or Toyn, State, Zip Co 2-Ballimore	"NH						
	20a,METHOD OF DISPOSITION 1 September 2 Cremation 3 Removal f 4 Donation 5 Other (Specify)	rom State 20b. PLACE AND DATE OF DISPO cemetery demator or other place	SITION (Name of	BATE 20c. LOCATION - GIN	or Town, State						
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E O 1 0 22	NAME AND ADDRESS OF FACIL	uny Duss +	Eneral HM						
Н	23 PART Enfer the diseases or comp	Hicationa thei caused the death. Do not ente	Dasow. n.	orth are Ba	torMo						
	IMMEDIATE CAUSE (Final	only one cause on each line.		an cardiac or respiretory arrest	Approximate interval Between Onset and Death						
	disease or condition reaulting in death)	DUE TO (OR AS A CONSEQUENCE OF):	CINOMA -	lung							
NO	Sequentially list conditions,										
-ICAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	that initiated events resulting in death) LAST	out to forthe a constructive or).									
A P	PART II. Other algnificant conditions con	ntributing to deeth but not resulting in the u		art I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO						
MEDIC	Hypertens,	the polymonry do	JeAse	1 - YES 2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
AN:	DID TOBACCO USE CON	NTRIBUTE TO CAUSE OF DEA									
PHYSICIAN:	EXAMINER? HO	SPITAL: Nopetient 2 = ER/Outpatient 3 = DOA 4 = Nu	28. PLACE OF DEATH (Check R: Irsing Home 5 Residence 8								
	27. MANNER OF DEATH 1 Naturel 5 Pending	26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY M	29c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCUR	ED						
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At home, farm, street, fac building, atc. (Specify)	tory, office	281. LOCATION (Street and Number or City or Town, State)	Rural Route Number,						
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my knowledge, death occurred at the	time, data and place, and due to	the cause(s) and menner as stated.							
COM		the basis of examination and/or investigation, in my			euse(s) and menner as stated,						
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER COKEANNEY	MA	DZ7 80	29d, DATE SI	RONED (Month, Day, Year)						
	30. NAME AND ADDRESS OF PERSON WHO COL CHRISTOPHER	WPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	4 700 WF	BHBIVD BF	HIT MO						
	MAY 2 3 1995	32. REGISTRAR'S SIGNATURE			21230						



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGI			
		1. DECEDENT'S NAME (First, Middle, Leel) ZACHARY	OGERS		KELLY		2. DATE OF DEAT MONTH	H	year 5:45 P. M	
phonid		4. SOCIAL SECURITY NUMBER 220-29-8574 98. FACILITY NAME (If not institution, give si	1 XM 2 □ F 4	In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTTH (Month, Day, Yea	(r)	I. BIRTHPLACE (State or Foreign Country)	
1, 2, 3 sho	STOR	98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 99. COUNTY OF DEATH 99. COUNTY OF DEATH ANNE ARUNDEL RESIDENCE OF DECEMENT								
permit. Pages	DIRECTOR		ARUNDEL		Y, TOWN OR LOCA ASADENA	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
1Si	FUNERAL	10e. STREET AND NUMBER 8073 CROYDON WAY 11. MARITAL STATUS			- 4	21122		U.	S.A.	
215-0020 attending physician. se as the burial-tra	₽	Never Merried 2 Married Wildowed 4 Divorced	FORCEST 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.)						4. RACE American Indian, Black, White, etc. Specify: WHITE	
21 21 or 10	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u				BUSINESS/INDUS	STRY	
	COMI	17. FATHER'S NAME (First, Middle, Last)	N/A	51	UDENT	18. MOTHER'S NA	PUBLI		OL SYSTEM	
MARYL retained by 5 should be	TO BE	ROBERT MICHAEL 19a. INFORMANT'S NAME (Types/Print)	KELLY	19b. MAILING	ADDRESS (Street	KIMBER	RLY D		VERHART OGEN	
щ э э э э	8	ROBERT MICHAEL KE		535 C	RESTPARK	DRIVE.	GLEN BUR	NIE. MD	. 21061	
IMORE, I	MUST	f ☐ Burial 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)	val from State ceme	etery, crematory or o	F MEMORI	TAT DADY	7633	LKRIDGE	MADVI AND	
ALT death.	examine	22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061								
this 24 hours tely filled in mation, or re	rem, me medical	23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A	UMOR (,			espiratory arrea	Approximate interval Between Onset and Death	
P.O. BOX th certificate be ex ending physician a Hygiene prior to	ry, or other traumatic event,	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
ORD ORD that the the th and M	MEDICAL CE	PART II. Other algorificant condition:	contributing to death bu	ut not reaulting	in the underlyin	g cause given in	PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2	
AL RI he law red has been Dept. of	AN: A	DID TOBACCO USE CONTR			S NO	UNCERTAIL	V 🗆		10 165 210	
上年 智智	PHYSICIAN	EXAMINER? 1 VES 2 NO	HOSPITAL:	itlent 3 DOA	OTHER:	ne 5 Xessidence	6 Other (Specify)	CHILD DIE	DO AT HOME	
O \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF 28c. INJ		26d. DESCRIBE HO			
ISIC TTENDI	TED	2 Accident Investigation 3 Suicide a Could not be determined	28e. PLACE OF INJURY building, etc. (Specific	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
	티		NAN: To the best of my knowledge, death occurred at the time, date and place, and di to On the basis of examination and/or investigation, in my opinion, death occured at the							
TO THE HOSPITAL TO THE FUNERAL DE filed within 72	TO BE (29b. SIGNATUME AND ITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WHO	shes			29c. LICENSE NUN	1071 MC		HIGHED (Mohith, Day, Year)	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR .

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OF ALLENDING FILLSCOALS, the law requires that the overlands of controlling injury of the most of a state of the most of the m	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s	afte	and the second section of the second
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ITEM: 1. PER F.H. FILM G-723 5/23/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Patricia Kluczynski PATRICIA FRANCES KLUCZYNSKI May 95 10:40 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) BIRTHPLACE (State or Foreign Country) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 212-36-2441 56 DAYS HOURS 1 M 2 K F VRS Sept. 26,1938 Maryland Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Riverview Nursing Centre, Inc. Baltimore Essex RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Dundalk Maryland Baltimore 1 TYES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21222 United States 7824 Lockwood Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuben, Maxican, Puerto Rican, etc.)
1 ☐ YES 2 ☐ NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 ND IF YES, GIVE WAR OR DATES 1 Never Married 2 A Merried BY Specify: 3 Widowed 4 Divorced White. 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Years Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Tuma William Jones BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Francis J. Kluczynski, St. 7824 Lockwood Road Dundalk, Maryland 21222 9 29a. METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 He
4 Donation 5 Other (Specify) OATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of T TEL "Sacretary Atter 10% Jesus Cem. 5/22/95 Dundalk. Maryland 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. lner 21. SIGNATURE OF FONGRAL SERVICE LICENSES 7922 Wise Ave. Dundalk. MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition 160Kena 1 day resulting in death) DUE TO (DR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE DF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Atteriocaleptic Ceschopanda 1 TYES 2 NO Apertencia 1 | YES 2 | ND PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 Sylvesing Home 5 Residence 8 Other (Specify) 1 TES 2 QUO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending Investigation 1 YES 2 ND BY 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide Hem 29e. CERTIFIER
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IMPORTANT: If its 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

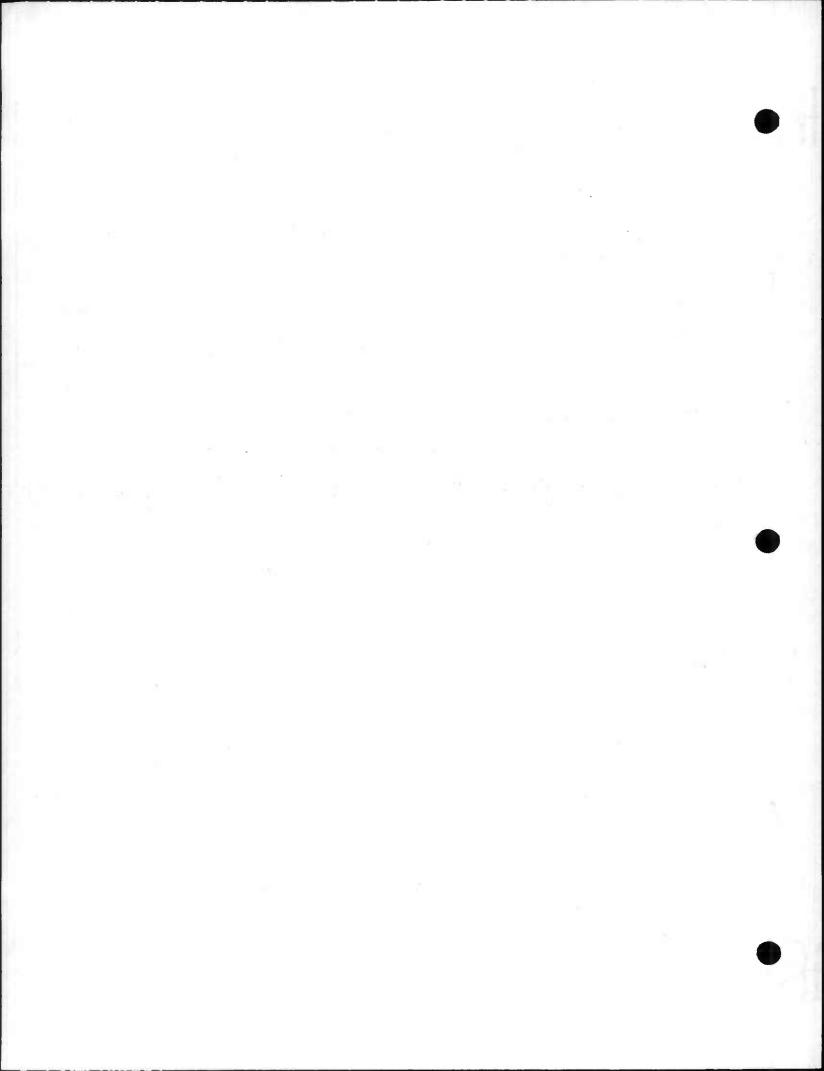
SIGNATURE AND TITLE DE CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER (hereach M) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael Schwartz 606 Hammonds Lane LL 32 REGISTRAR'S SIGNATURE

1995 P. S. 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT	OF H	EALTH DEAT	AND M	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	AME (First, Middle, Last)							lv .	YEAR	3. TIME OF DEATH
	BERNARD		FCHICK					MAY 17,		TEAN	9:35am M
	100 00 0100	SEX 8. AGE (In 79	yrs. last birthday)	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign y)
		G	YRS.					NOV. 23,	_		JERSEY
œ	Sa. FACILITY NAME (If not institution, give stree	t and number)		9b. CITY,		R LOCATIO		ATH		NTY OF D	EATH
5	SINAI HOSPITAL BALTIMORE N/A										
DIRECTOR	10a, STATE 10b, COUNTY		10c. CIT	Y, TOWN O	A LOCAT	ION					10d. INSIDE CITY LIMITS?
۵	MARYLANT 10e, STREET AND NUMBER	N/A		BA		10RE					1 X YES 2 NO
RA	5707 STUART AVE				101	2121				ZEN OF V	WHAT COUNTRY?
FUNERAL			J.S. ARMED	13. 1	MAS DEC			C ORIGIN? (Specify Yea			- American Indian,
YF	X	2. WAS DECEOENT EXER IN I FORCES? 1 YES IF YES, GIVE WAR OR OAT	2 NO	1	yes, sp	city Cubar	Maxican, Specify:	, Puerto Ricen, atc.)	or No-	Black	t, White, atc.
Э ВУ	3 Wildowed 4 Divorced		WWII				ороспу.			apec	WHITE
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	noleted)	Give kind of the life. Do NOT us	work done o	CUPATIO	N st of working	7	16b. KIND OF BUS	INESS/INO	USTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+			LOG.	ST		INSECT O	CONTR	OL 8	RESEARCH
OM	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	FR'S NAM	E (First, Middle, Maiden			
BE C	MAX	KR.	AFCHICK			MOL			ourname,	E	BERMAN
TO B	19a, INFORMANT'S NAME (Type/Print)							oute Number, City or Town			
۲	MRS. URSULA KRA	FCHICK	5707	7 STU	ART	AVE.	BAL	TIMORE, MI	212	15	
	20a. METHOD OF DISPOSITION 1 To Burlel 2 Cremation 3 Remova		BALTIMO				-		CATION —	,	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN		DALITIO			D ADDRES	_	-19-1995	KEIST	LERS.	IOWN, MD
	· Lintell	1 Buttle		8	OL	LEVIN	ISON	& BROS.,			
\dashv	23. PART I. Enter the diseases, or com	polications that caused t	he deeth Do r	ot enter	OTO	REIS	TERS	STOWN ROAD	BAL	LIMO	RE, MD 21215
	shock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Only one cause on each of the Control of the Contro	h line.						atory arr		Approximata Interval Between Onset and Death
_	_	DUE TO (OR AS A C	ONSEQUENCE OF	F):		X	Chr	4 17			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF	F):	*		- 0 -)	7 - 4			
3	CAUSE (Disease or Injury										
	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	F):							
	d										
PHYSICIAN: MEDICAL	PERFORMED? 1 YES 2 NO OF DE									WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	PLACE OF OEAT	OTHER							
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BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY -	At home, ferm, s	street, facto				28f. LOCATION (Street a	nd Number	or Rural A	oute Number,
ETED	4 Homicide datermined	building, atc. (Specify	,					City or Town, State)			
29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
										and manner as stated.	
띪	296. SIGNATURE AND TITLE OF CERTIFIER	Illas	ill.			29c. LICEN	10 Y		29d. DATE	SIGNED	(Month, Day, Year)
2		ASSER	H (ITEM 27) (Type,		p.	100			چ ۔	120	R.
	31. MAY 2 3 1995 Jul	32. EGISTRAR'S SIGNAT									



3. TIME OF DEATN

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24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

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▶ 5.22.95

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BAGIMPE MD

14. RACE — American India: Black, White, etc.

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9c. COUNTY OF

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10g. CITIZEN OF WHAT COUNTRY?

Specify:

2. DATE OF DEATH PWIS mai 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year SPO + 17, IF UNDER 1 YEAR | IF UNDER 24 HRS VRS permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give 9b. OFTY. TOWN OR LOCATION OF DEATH sto 8 DIRECTOR d a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY TOWN OR LOCATIO nda 5 town FUNERAL 10e. STREET AND NUM 0 been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit of Health and Mental Hygiene prior to burial, cremation, or removal. D hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-H was specify Cuban, Mexican, Puerto Rican, etc.) WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married If yes, specify Cube
1 ☐ YES 2 ▼ NO BY Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ry/Secondary (0-12) College (1-4 or 5+) once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME-(First, Middle, Malden Sur notified at 201 19b. MAILING ADDRESS 2 ewis 0 le pe 20e METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must nation 5 - Other (Specify) ZYP S examiner 21. SIGNATURE OF FUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F. H. West 0 4300 Wabast medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** the lignan disease or condition a Youla reaulting in death) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY jake tes PERFORMED? shows any 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) : After this certificate hir death with the State E HOSPITAL OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 8 ☐ Other (Specify) marked, or 27 MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: A 89 3 COMPLETED 6 Could not be . 28 4 Nomicide Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite (Check only one) end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Sheldon Goldgeier, 9

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, (Time)

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

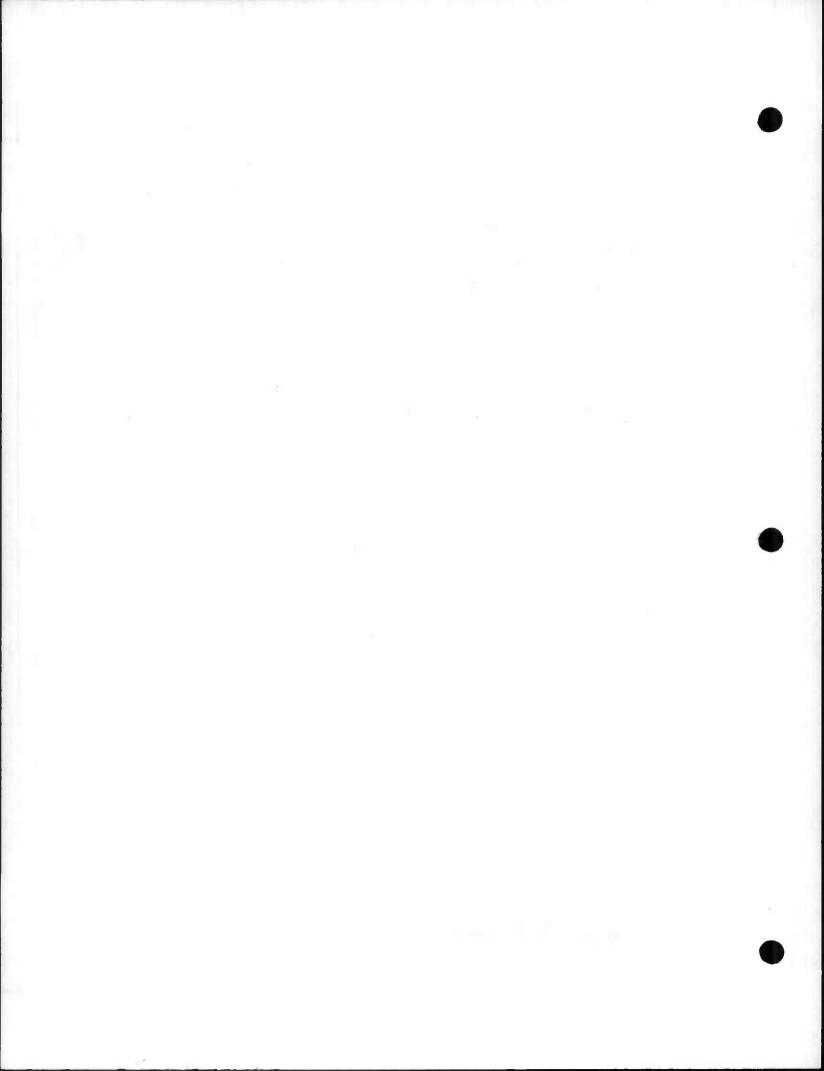
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Sheldon

31. DATE FILEO (Month, Day, Year)
MAY 2 3 1995

1. DECEDENT'S NAME (First, Middle, Last)

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Warren Maley, M.D.

31. DATE FILED (Morth, Day, Vest)

MAY 2 3 1995

	1 - STATE REGISTRAR	STATE OF MARYL		ICATE OF		MENTAL HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last) Katherine	Troiano	Lel	nar		2. DATE OF DEATH MONTH MAY 10,	1995 YEAR	3. TIME OF DEATH 10:13a		
	4. SOCIAL SECURITY NUMBER 212-70-3220	1 🗌 M 2 💢 F	(In yrs. last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct 10, 19	Countr	HPLACE (State or Foreign ry) Lington, D.C		
	9a. FACILITY NAME (If not institution, give str	,			OR LOCATION OF D	EATH	9c. COUNTY OF D			
CTOR	Johns Hopkins Hos	pital		Ва	ltimore		N/	A		
DIREC	10a. STATE 10b. COUNTY		10c, CI	Y, TOWN OR LOCA	TION			10d. INSIDE CITY		
		ltimore		Catonsv	ille			1 YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			10	of. ZIP CODE		10g. CITIZEN OF V	VHAT COUNTRY?		
N N	927 Vanderwood Ro				21228			SA		
B⊀	1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	If yes, s	CENDENT OF HISPA: pecify Cuban, Maxico S 2 X NO Specif	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No — 14. RACE Black Speci	E — American Indian, k, Whita, atc. Hy: White		
ED ED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)		USUAL OCCUPATI		16b. KIND OF BU	SINESS/INDUSTRY	***************************************		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT u	se retired.)						
OMP	17. FATHER'S NAME (First, Middle, Last)	2	Lab	Technic			edical			
E C				Joan	AME (First, Middle, Maiden Christi		arta			
0	19e. INFORMANT'S NAME (Type/Print)	Troiano	19b. MAILING	ADDRESS (Street		Route Number, City or Tow		arta		
2	Mohamed Lehar					Baltimore		228		
	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo	val from State	PLACE AND DATE		lame of	DATE 20c. LO	CATION City or To	wn, Stata		
	Dulaney Valley Mem. Gardens May Timonium, Maryland									
	DYALU.	Clary-			on Funera					
	Bryan W. Clary 10 W. Padonia Road, Timonium, MD 21093 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that couse list only one cause on e	d the death. Do a each line.					Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition	1.000		34	Donald & Isturate mo ZMOT.					
	reaulting in death)	DUE TO (OR AS	A CONSEQUENÇE O	n: D	1 ADE	400		12mg		
Z	Commenter to the control of the	D400	s also	ces	JAH.	ROVER	mo	7 mor		
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	QUE TO (OR AS	CONSEQUENCE O	<u>F):</u>		TU-	UCME	7 111 01		
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OH AS A	CONSEQUENCE O	Marc	~		OIVIE	1000		
E	resulting in death) LAST	luml	Jan A	1pino	YF,	selen	2	1454		
E CE	PART II-Other significant conditions	contributing to death h	out not constitue	in the underhein	n names dhan is	nest Leaven		1 1		
MEDICAL	Cenal lu	where		20.	The land	PERFOR	MEDT.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDI	English Syndrone, Hapitic Dyslamation 1 YES 2/5, NO COMPLETION OF CAUSE									
2	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YE	S INO	UNCERTAIL	N D		I C YES 2 X NO		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	***	~					
IYSI	1 V YES 2 □ NO	1 Cinpatient 2 - ER/Outs			me 5 🗆 Residence	The second secon				
PHY.	27. MANNER OF DEATH 1 Natural 5 Pending	9 Month Day Young			DRKT	264 DESCHIES HOW I	HJURY OCCURED	2 . 0		
9	2 Suicident investigation 3 Suicide 6 Could not be	28 PLACE OF INJURY	— At home, farm.	7 1		281, LOCATION (Street a	and Number or Rural S	Pouts Number		
TED	4 Homicide 6 Could not be detarmined	building, atc. (Spin	0			Party Kees	Kt SN. P.	where		
PLET	29s. CERTIFIER CERTIFYING PHYSIC	SAN: To the best of my know	ledge, death occurr	ed at the time, date	and place, and due	to the cause(a) and there	1200	· MIX		
COMPL		In the beats of symmination) and manner as stated.		
	216. SIGNATURE AND THE OF CERTIFIED	11/2/8.	1.11		29c. LICENSE NUI	MBER	29d. DATE SIGNED	(Month, Day, Year)		
TO BE	July		(my)		W47	42	▶ 5/17			
TO BE COMP	30. NAME AND ADDRESS OF PERSON WHO		1							
	Warren Maley, M.D.	- property of the last of the	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS	St., Bal	ltimore,	MD 21287				
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ge 6 may be retained by the hospital or attending physician.	irector, page 5 should be detached for use as the burial-transit permit Pages 1.2.3		r must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 > 3	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

should

. 95 15732 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Martin Lear 18,1995 May 8:22A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year)
NOV. 17,1917 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 ... M 2 ... F YRS. Maryland 213-12-6462 Sa. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Perry Point V.A. Hospital Perry Point Cecil Co. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Queens Anne Stevensville 1 TYES 2 X NO FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 107 Northwest Creek Dr. U.S.A. 21666 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married BY 3 ₩ Widowed 4 Divorced Specify: WW11 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY Tate Architectial Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Quality Control Inspector Products 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martin Lear BE Mary Elizabeth Howard 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Diane Miller 107 Northwest Creek Dr. Stevensville, Md. 21666 20e. METHOD OF DISPOSITION

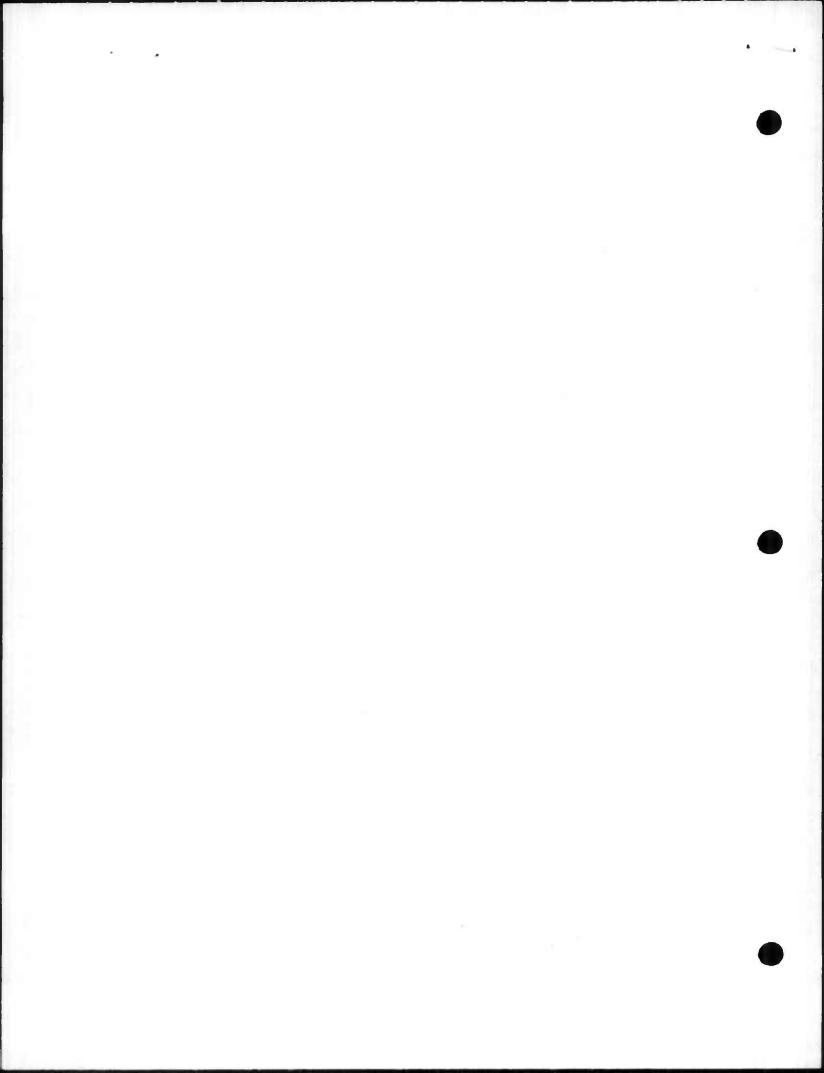
1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State ary, crematory or other place) Woodlawn Cemetery 4 Donation 5 Other (Specify) Woodlawn, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home 3204 Mountain Rd Pasadena Md. 21122 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only/one cause on each line. interval Between IMMEDIATE CAUSE (Figal Onset and Death disease or condition / . Congestive Heart Failure reaulting in death) DUE TO (OR AS A CONSEQUENCE OF Coronary Artery Disease
OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Diabetes Mellitus 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER: 1) Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month. Day, Year) 5-18-95 D37093

VA Medical Center, Perry Point, MD 21902

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTANNE CLOEREN, M.D., 132. FOISTPARS TOWN THE MAY 2 3 1995

DHMH-16 Rev 1/89



		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
		1. DECEDENT'S NAME (First, Miche, Last) TABRIA R. LE	wis (Baby	girl)			2. DATE OF DEATH DAY		AY	YEAR 3.	6:50 Pm	
Pie		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (IN yrs.	YRS. I I I I I I I I I I I I I I I I I I I	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH			CE (State or Foreign	
l, 2, 3 should	стов	98. FACILITY NAME (if not institution, give str UNU of MO RESIDENCE OF DECEDENT	Mudical Ce			er location of di				Y OF DEATH	ryre	
nit. Pages 1	DIRE	MD BAL	TIMORE			ION MORE					I. INSIDE CITY LIMITS? YES 2 NO	
ian. transit permit.	NERAL	100. STREET AND NUMBER 306 N	Bruce Street			2122			6	S A	COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES	ARMED 13	if yes, spe	ENDENT OF HISPAP ecify Cuben, Mexice 2 NO Specify	n, Puerto	N? (Specify Ys: Ricen, etc.)	s or No 1/	Black, Wh	American Indian, iller, etc. BLACK	
21 al or for u	LETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	ATION 16e. College (1-4 or 5 +)	DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired.	e durina mas		166	. KIND OF BU	SINESS/INDUS	STRY		
the hospital detached it	COMPLET	17. FATHER'S NAME (First, Middle, Last)		// /	<i> H</i>	16. MOTHER'S NA	ME (First,	Middle, Malden	Surneme)			
7 2 2 4	BE	TERRY 19a. INFORMANT'S NAME (Type/Print)	RICHA	PROSON		GLOR Number of Burni	P/A	has Clin as You		LEV	V/5	
be re ge 5	10	GLORIA	LEWIS	306 N.	BRO	ICE S	Tick	3ALTI	MORE	MO	21223	
O E E		20 METHOO OF DISPOSITION 10 Burial 2 Cremetton 3 Remont 4 Dogetton 8 Other (Specify)	val from State cemetery,	CE AND DATE OF DISPO	BAB	VLAND	5-/	2-95	CATION — CIT		State RE, MD,	
9 - 9 -		JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223										
within 24 hours after piperely filled in by the cremation, or removal ent, the medical		23. PART I. Exter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, interval Batwee Onset and Dad disease or condition resulting in death) a. Cerebral herniation.										
P 5 5 5		resulting in death) a.	DUE TO (OR AS A CONS	ISEQUENCE OF:			0 1		,			
be ex	CERTIFICATION	Sequentielly list conditions, If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury C. DISSEMINATED INTRAVASCUCAR COAGULOPATER.										
frate physical B	TIFIC/	CAUSE (Diseese or Injury that initieted eventa	OUE TO (OR AS A CONS	SEQUENCE OF):			UCAT	R COP	Gulo	GULOPATTIV.		
S, P. death of attend ental Hy. or		resulting in death) LAST		- Premo								
2 2 2 2	MEDICAL	PART II. Other algnificant conditiona	contributing to deeth but no	ot resulting in the u	indarlying	ceuse given in	Part I.	24a. WAS AN PERFOR	RMED?	AVAI	RE AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?	
0	N. M	DID TOBACCO USE CONTR	BUTE TO CAUSE OF DE	EATH YES	NO 🗆	UNCERTAIN	10			1 [YES 2 NO	
上 年 8 8 5	PHYSICIAN:		26. PL HOSPITAL: 1X Inpatient 2 - ER/Outpatient	LACE OF DEATH (Check	R:	5 Reeldence	« X ov.	r (Specify)				
	100	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJU WOF	IRY AT		SCRIBE HOW I	NJURY OCCUP	RED		
ISION ITTENDING TOR: After after death 28 is ma	TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY — At building, etc. (Specify)			ES 2 NO		ATION (Street or Town, State)	end Number or	Rural Route	Number,	
	COMPLET		AN: To the best of my knowledge, On the basis of examination end/s								menner ee stated.	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	TO BE C	286. BIGHATURE AND TITLE OF CERTIFIER	no / Alsay	peli		29c. LICENSE NUM D 3 9 3	IBER	1	29d. DATE S			
		30. NAME AND ADJRESS OF PERSON WHO Alakananda B	ag chi, MD	TEM 27) (Type, Print) 22 S.	Gree	ene She	eet	N568	-, Ba	Him	re MD 2/2	
		MAY 23 1995	72. DEGISTRAR'S SIGNATURE			·····						

= Family State of

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32. REGISTRAR'S SIGNATURE

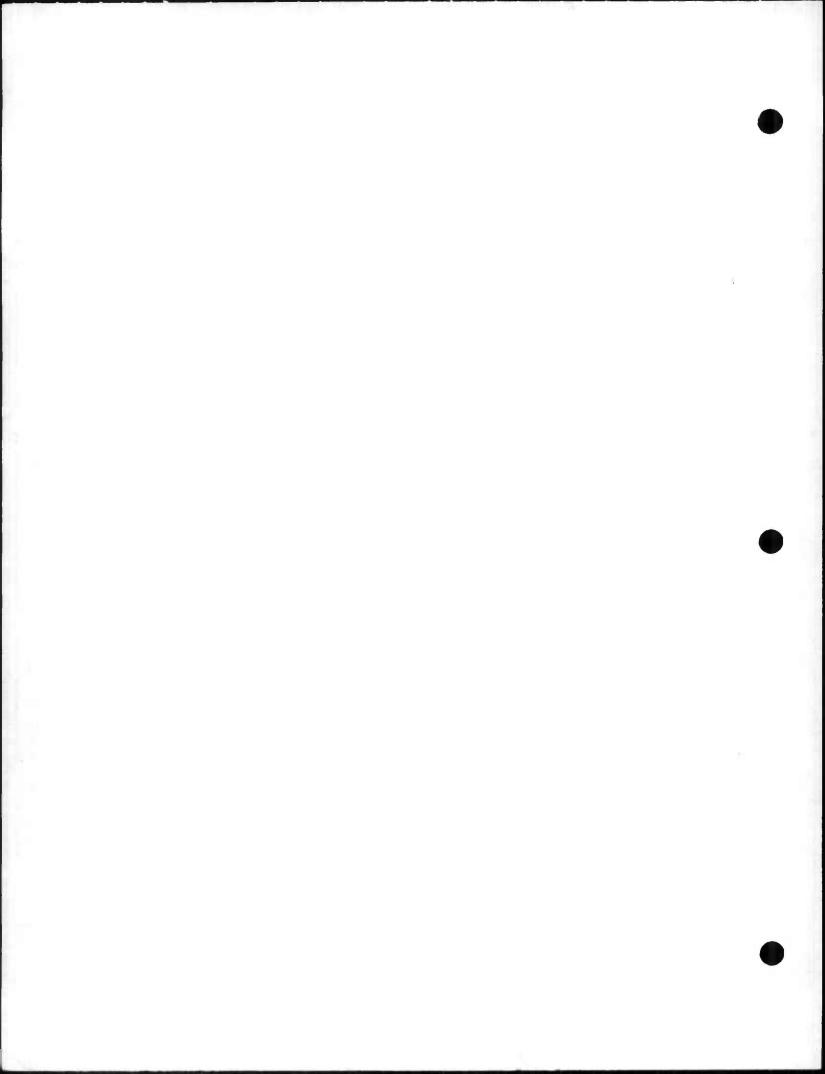
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permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 TONY LOMAGNO MAY 16 09:15 A M A SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 191-03-7843 1 XM 2 F 80 YRS. June 16, 1914 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital, 900 Caton Ave. Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3330 Wilkens Ave. 21229 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married ecify Cuban, Mexican, Puerto Rican, atc.) 1 YES 2 NO SpecMy: white BY 3 Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION sectly only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Ship Building & Dry Dock 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barney Lomagno Margaret Valeri BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Lomagno #6 8th Avenue, Baltimore, MD 21225 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Buriel 2 Cremetion 3 Removal from State 1 Burial 2 Cremation 3 1 1 4 Donation 5 Other (Specify) H. SIGNATURE OF FUNERAL SERVICE LICENSEE RODALD Wade, Dir. 22. NAME AND ADDRESS OF FACILITY State Anatomy Board emous 655 West Baltimore St., Balto., MD 21201 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Death se or condition neumonia resulting in dasth) Hours DUE TO (OR AS A CONSEQUENCE OF) Recurrent Aspiration CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING Cerebrovascular CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO Dementia COMPLETION OF CAUSE 1 | YES 2 | THO OF DEATH? 1 YES 2 HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{2}\) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 M DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — Al home, term, street, factory, office building, atc. (Specify) Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER FIGHTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and menner as stated. # MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(a) and manner as stated. 296. SIGNATURE AND TITLE OF CENTERES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D35572 MAY 16 1995 2 36. NAME AND ADDRESS OF PERSON David J. Kahan, mp

Baltimore, MD, 21229



retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be DIVISION OF VITAL RECORDS, P.O. BOX 68760

funeral director, page 5 should be detached for use as the burial-transit signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. the death certificate be executed within

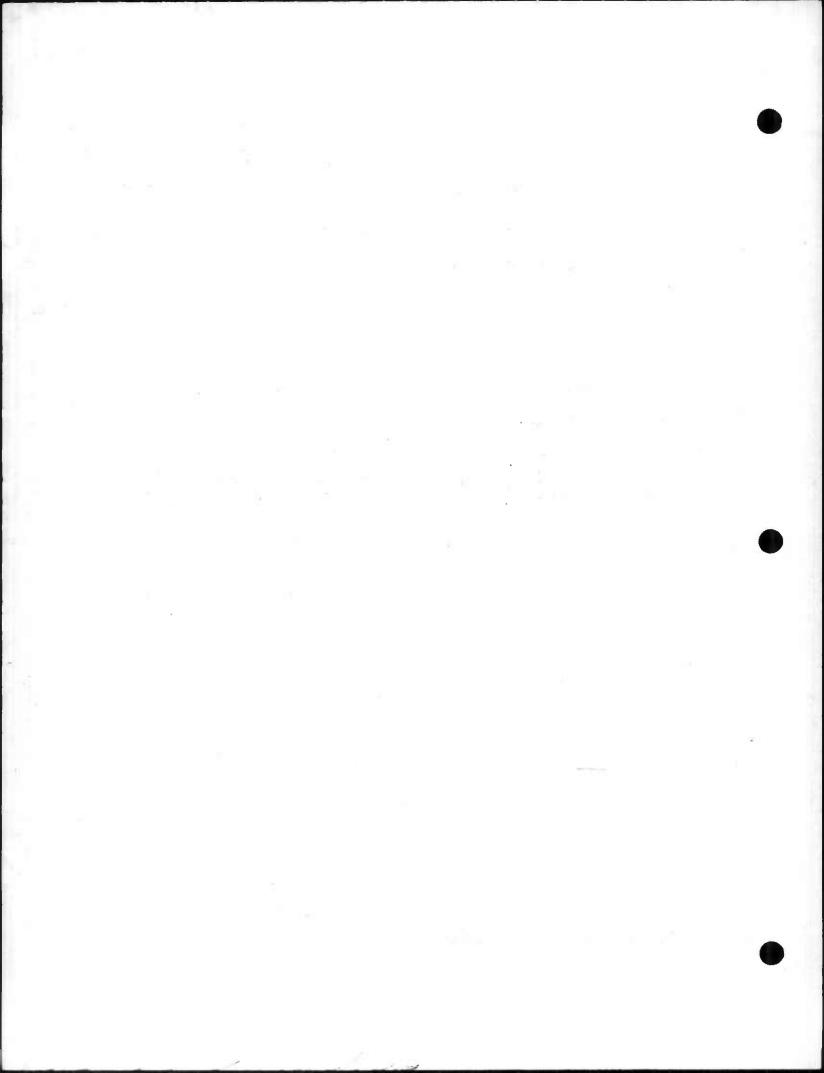
OR ATTENDING PHYSICIAN: The

HOSPITAL

31. DATE FILED (Month, Day, Year) MAY 2 3 1995

32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ANDRE McLEOD MAY 995 :10 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (Ste 1 Au 2 1 216-43-9560 YRS. 27 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Pages 1, 2, 3 DIRECTOR BON SECOUR HOSPITAL RESIDENCE OF DECEDENT N A E.R BALTIMORE CITY 10b. COUNTY 100 CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md 140 permit. 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 18 21223 USA 0 12. WAS DECEDENT EVER IN U.S. ABME FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cubs IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: Specify: lack COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
The blad of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specif (Give kind of work done life. Do NOT use retired. College (1-4 or 5+) 2 once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname estopher Hondo notified at BE a 19b. MAILING ADDRESS (Street and Number or Rural Route Nu 2 + (a 51553 Pe METHOD OF DISPOSITION
Burlal 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 20c. LOCATION - City or Town, State ing Memorial Donation 5 - Other (Specify) Park 52495 Randallstown, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 51212 you 4300 Waba 0 the medical dieeesea, or complications that caused the deeth. Do not anter the mode of dying, auch as cardiac or respiratory arrest, Approximate shock, or neert fallure. List only one cause on each line. **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition SUDDEN INFANT DEATH SYNDROME resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO jo DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 has b 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate In the State HOSPITAL:
1 | Inpatient 2 | RER/Outpatient 3 | DOA OTHER: 1XXES 2 □ NO ing Home 5 - Residence S - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) this c. 28c. INJURY AT 28b. TIME OF INJURY marked, 28d. DESCRIBE HOW INJURY OCCURED 1XX Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 3 Suicide 99 ETED. 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 28 COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 ho (Check only one) XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. IGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E MAY 18,1995 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDOURD D-KOREW W) 111 Penn Street, Baltimore, Maryland 21201



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR

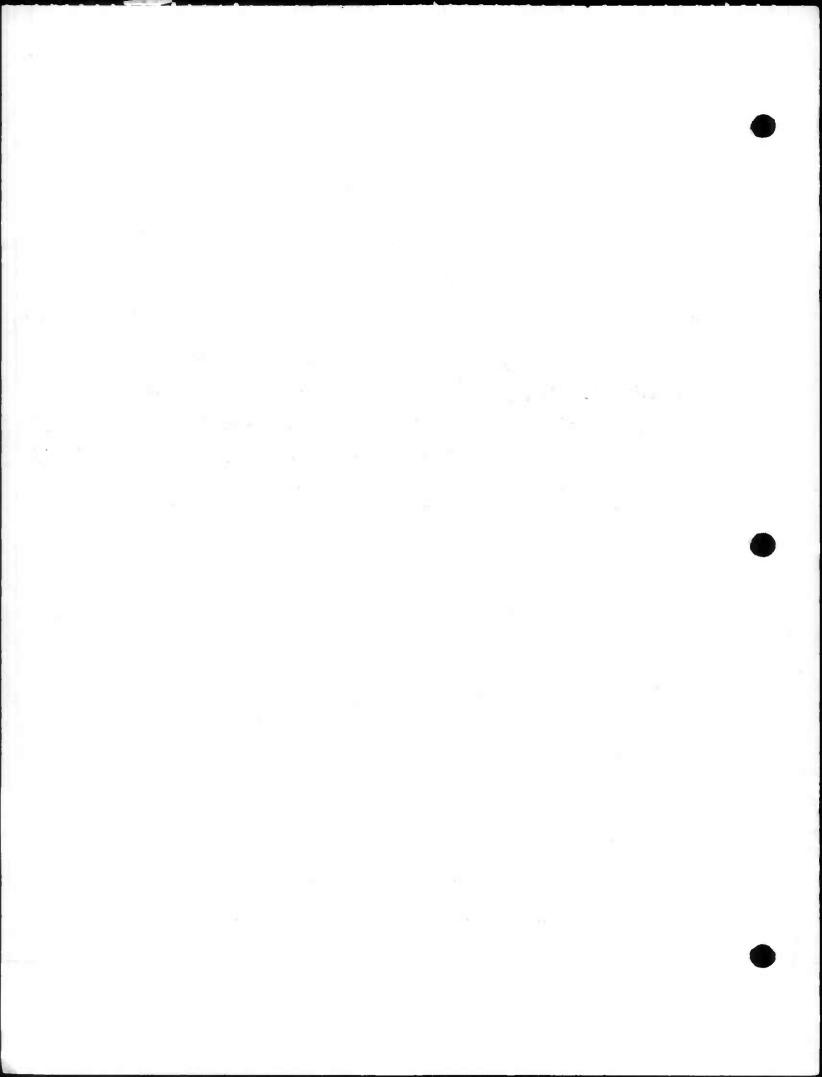
		REGISTRAN		OLITINI	SAIE OF	DEATH	REG. NO		
	1	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH(4 + 44()
	- 1	MATILDA M	URRAY				May 21	1995	Such OAM
		4. SOCIAL SECURITY NUMBER	5. SEX	In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	B. BIF	TTHPLACE (State or Foreign
	- 93	216-16-4116	1 - M 2 F 8	YRS.	ONTHS DAYS	HOURS MIN.	1 (Mouth, Day Year) 1	914 M	aryland
	- 1	9a. FACILITY NAME (If not institution, give str	set and number)		Bb. CITY, TOWN (OR LOCATION OF D	EATH	9c. COUNTY Q	
	E	RAN SECOL	r Hace	vital	Ba	Itim	(1100	N	A
	DIRECTOR	RESIDENCE OF DECEDENT	1 110.5	TIQI I			016	1.4	111
	Ä	10s. STATE 10b. COUNTY	11/1	10c, CITY,	TOWN OR LOCA	TION	100		10d. INSIDE CITY
	ā	Maryland 1	VIA	1 Bo	altim	1010			1 (52 YES 2 NO
	AL	10e. STREET AND NUMBER	relia.		10	1. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
	E E	2561 Seamo	in AVE			2123	25	1/1	5A
	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMEO	13. WAS DEC	CENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No.— 14, R/	ACE — American Indian,
		1 Never Married 2 Married	FORCES? 1 YES			ecify Cuban, Maxica 3 2 NO Specif	en, Puerto Rican, etc.)		lack, White, etc.
	В	3 Wildowed 4 Divorced					,.	1 "	Black
		15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U	SUAL OCCUPATION	ON on working	16b. KIND OF BU	SINESS/INDUSTRY	1
	딕	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	oat or working	11	1. 1	
ad	MP	10		Dom	esti	C	1 110	rel	
at once	COMPLET	17-FATHER'S NAME (First, Middle, Last)	1/			18 MOTHER'S NA	ME (First, Midelle, Maiden	Surname)	
at I	BE (William 10	arker			Mar	v Par	-Ker	
medical examiner must be notified	0	19a-INFORMANT'S NAME (Type/Print)	14	19b. MAILING A	DDRESS (Street a	and Number of Rural	Route Number, City or Tow	n, State, Zip Code)	
2	F	Edward Pa	rker	3803	Gra	nada	Ave. B	alto, [Md. 21207
t p		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remove	20b	PLACE AND DATE OF	DISPOSITION (No	emp of	OATE / 20c. LO	CATION - City or	Town, State
Ē	i	4 Donation 6 Other (Specify)	val trom State cem	of Company	ern	Star	\$194/15 CC	itansi	ille Md
ner		21. SIGNATURE OF FUNERAL SERVICE/LICE	INSEE O. O		22. NAME A	ND ADDRESS OF FA	CILITY	, 11	
жаш		* MADINA	I. K	111/	Jose	ph Lik	uss fun	egal, H	ome 2/2/
cal e		23 PAST V Fotos the disease	<u> </u>	(11)	1200	2 W. Ni	orth Ave	. Daliti	D.14d.21216
Dem		23. PART Enter the diseasea, or co shock, or heart failure. L	ist only one cause on a	i the death. Do no ach iine.	t enter tha mo	ode of dying, suc	th as cardiac or respi	ratory arreat,	Approximate interval Between
	1	iMMEDIATE CAUSE (Final disease or condition	,	1 -		0 -			Onset and Daath
H.,		resulting in death) a			1011	MEUM	AJNO		flow days
or other traumatic event, the			OUE TO (OR AS A	CONSEQUENCE OF):					,
atic	N	Sequentially list conditions,							
an an	Ĕ	If any, leading to immediate	OUE TO (OR AS A	CONSEDUENCE OF):					
1	3	CAUSE (Disease or injury					·		
9	Ē	that initiated evants reaulting in death) LAST	DUE TO (OR AS A	CONSEDUENCE OF):					
	CERTIFICATION	d.							
any injury,		PART ii. Other aignificant conditions	contributing to death b	ut not resulting in	tha undariyin	g causa given in	Part I. 24a. WAS AN	AUTOPSY :	24b. WERE AUTOPSY FINDINGS
n y	EDICAL	SEPSIS					PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
W S							1 _ YES 2	NO	OF DEATH?
	Σ	DID TOBACCO USE C	ONTRIBILITE TO	CALICE OF	DEATH \	VEC ET NIC		`	1 TES 2 NHO
23 she	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CITICIDULE IO	CAUSE OF					
Item	딣 등	EXAMINER?	HOSPITAL:		THER:	LACE OF DEATH (Ch			
6	₹	27. MANNER OF OEATH	1 Inpatient 2 ER/Outp. 28a. DATE OF INJURY	28b. TIME			6 Other (Specify)		
marked.		1 Natural 5 Pending	(Month, Day, Year)	INJUI	RY WC	JURY AT ORK?	28d. DEŞCRIBE HOW I	NJURY OCCURED	
E	B	2 Accident Investigation	60 Pt 405 OF 11 11 11 11			YES 2 ND			
28 18	0	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, tarm, str :/fy)	eet, tactory, offic	ca .	28t. LOCATION (Street in City or Town, State)	and Number or Run	al Route Number,
10	DJ 1						L		
E	E		IAN: To the heat of my knowl	ledge, death occurred	at the time, data	and place, and due	to the cause(s) and mer	nner as stated.	
I tem		29a. CERTIFIER 1 CERTIFYING PHYSIC	The state of the known						
NT: If Item		(Check only	: On the basis of examination	and/or investigation,	In my opinion, o	death occured at the	time, data and place, an	d due to the caus	e(s) and menner as stated.
RTANT: If Item	COMPLET	(Check only		and/or investigation,	In my opinion, o	29c. LICENSE NUI	MBER		
PORTANT: IF	BE COMPLET	(Check only one) 2 MEDICAL EXAMINER		n and/or investigation,	In my opinion, o	29c. LICENSE NUI	MBER		
	E COMPLET	(Check only one) 2 MEDICAL EXAMINER	: On the basis of axamination		bring)	D-4°	MBER	≥ May	J 21, 1995
PORTANT: IF	BE COMPLET	(Check only 1 GERTIFYING PHYSIC One) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	COMPLETED CAUSE OF DE		bring)	D-4°	MBER 0 521	≥ May	
PORTANT: IF	BE COMPLET	(Check only 1 GERTIFYING PHYSIC One) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P OURS WEST	bring)	D-4:	MBER	≥ May	J 21, 1995

BALTIMORE, MARYLAND 21215-0020	fours after death. Page 6 may be retained by the hospital or attending physicia
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BA	urs after dea
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OX 68760,	be executed with
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'AL RECORDS, P.O. BOX 68760,	he law requires that the death certificate be executed within

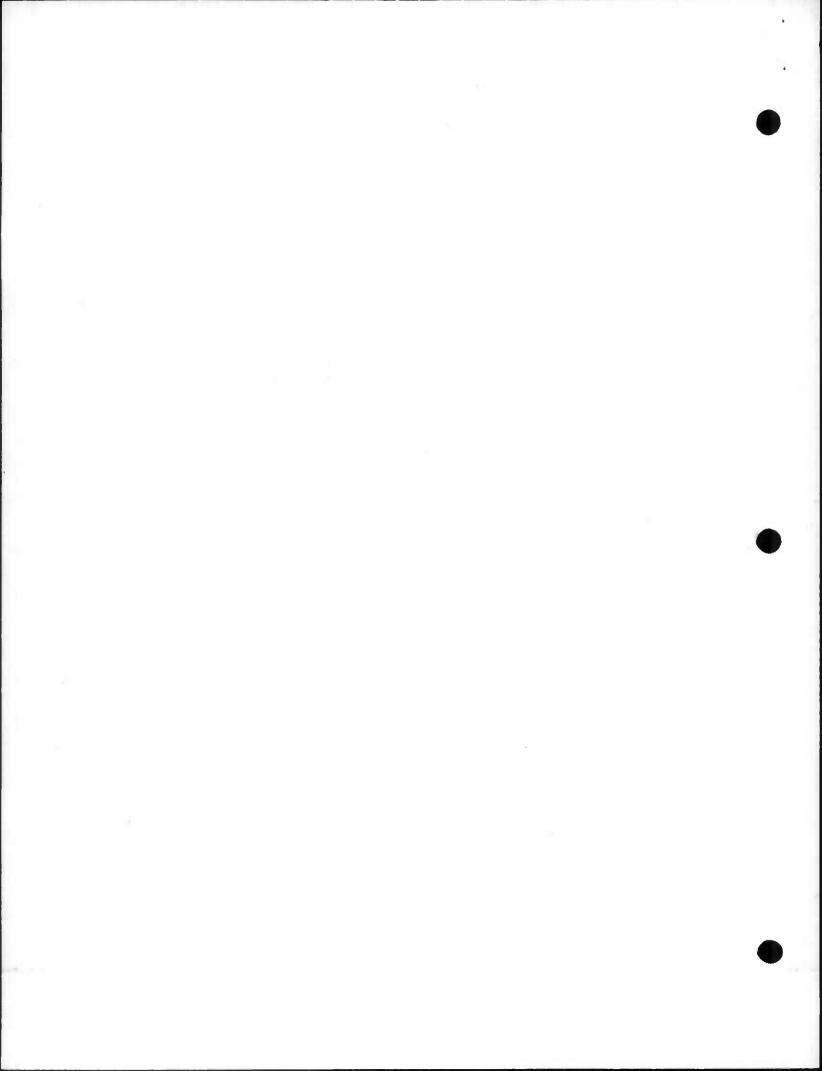
) THE HOSPITAL OR ATTENDING PHYSICIAN) THE FUNERAL DIRECTOR. After this certific ; filed within 72 hours after death with the S	ING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	leath with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.
THE HOSPITAL OR ATTEN THE FUNERAL DIRECTOR: filed within 72 hours after	DING PHYSICIAN: The	After this certificate his	death with the State D
	THE HOSPITAL OR ATTEN	THE FUNERAL DIRECTOR:	filed within 72 hours after

STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	D MI		GIENE G. NO.
(e, Lest)	12	. DATE OF DE	
McBride		May	20

		1 - STATE STATE OF MARYLAND / DEPARTMENT OF H CERTIFICATE OF	
		1. DECEDENT'S NAME (First, Middle, Lest)	2. DATE OF DEATH 3. TIME OF DEATH
		Forrest B. McBride	May 20 95 2:40 PM M
		4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 69 9 PRS. 1 MONTHS 1 DAYS	FUNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) HOURS MIN. Mar. 23 1926 North (aroling) Aroling
3 should	_	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN O	DR LOCATION OF DEATH 9c. COUNTY OF DEATN
5	E	Fort Howard VAMC BQ	Itimore N/A
020 physician. burial-transit permit. Pages 1,	DIRECTOR	Maryland 106. COUNTY NA 106. CHEY TOWN OR LOCAT.	100 10d. INSIDE CITY LIGHTS? 1 ✓ YES 2 ☐ NO
n. ansit perm	FUNERAL	6700 Brighton St.	ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?
9 g a	BY FUN		
1215 r attend use as		15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATIO (Give kind of work done during mos	ON 166. KIND OF BUSINESS/INDUSTRY
VD 21; nospital or ched for us	COMPLETED	(Specify only highest grade completed) Elementary/Secondary (6-12) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +)	Orderly Hospital
MARYLAND 21 retained by the hospital or 5 should be detached for notified at once.	BE CO	Marcus McBride	16. MOTHER'S NAMER (First, Middle, Melden, Surname)
60 41	70	Marcus McBride 3833 E, Jo	nd Number or August Ployte Number City or Town, Steep. Zip Code) DDA Rd, APT. A-1 Balto, Md2/236
ALTIMORE, I leath. Page 6 may be funeral director, page.	:	20e, METNOD OF DISPOSITION 1 METNOD OF DISPOSITION 1 Donation 5 Other (Specify) 20b, PLACE AND DATE OF DISPOSITION (Na certifiety, crematory or ôther place)	- Drest 9/24/2+ Owings Milk Md.
0 0		21. SIGNATURE OF FUNERAL SERVICE CENSEE ALCOK ALCOK 22. NAME AN 105 E 22. NAME AN 22. NAME AN 22. NAME AN 22. NAME AN 22. NAME AN 22. NAME AN 105 E	2 W. North Ave. Batto. Md. 21216
ours at our cours at our remu		23. PART Enter the diseases, or complications that ceused the deeth. Do not enter the mod shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine)	de of dying, such as cerdiec or respiratory arrest, Intervel Batween Onaet and Death
nati	ĺ	disease or condition	4 months
B 2 - 2		DUE TO (OR AS A CONSEQUENCE OF):	
66 and and bur	Ö.	Sequentially list conditions, If any, leading to immediate ARDS (Adult Respiratory Distribution ARDS) Due TO (OR AS A CONSEQUENCE OF):	tress Syndrome) 1 month
BOX cate be en physician as prior to	SAT	couse. Enter UNDERLYING CAUSE (Disease or Injury	4 years
oth partition of the pa	CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF):	
DS, P. or death or the attendi Mental Hy	E E	d. Coronary Artery Disease	
ORI that the ed by th and any is	PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying Multiple CVA's, Dysphagia, S/P Jejunostomy,	
REC requires been sign of Heal	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	1 YES 2 NO
AL Pass	IAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	UNCERTAIN 🗹
F VITAL SICIAN: The law certificate has in the State Dep	Sic	EXAMINER? 1 YES 2 \$4 NO HOSPITAL: 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome	5 Gaaldenca 6 Other (Specify)
OF PHYSICI this cert with the	E	27. MANNER OF DEATN 286. DATE OF INJURY 286. TIME OF INJURY (Month, Day, Year) INJURY WOOD INJURY	URY AT 284. DESCRIBE NOW INJURY OCCURED
ON OF ING PHYS (ter this cleath with marked,	BY	2 Accident Investigation	ES 2 NO
DIVISION OF VIOUS OR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St Item 28 is marked, or it	ETED	3 Suicide S Could not be determined 28e. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, de	
TO THE HOSPITAL TO THE FUNERAL Se filed within 72	ш	296. SIGNATURE AND TITLE OF CENTIFIER	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
5 5 3 M	TO B	of Dam	D30528 > 5/21/95
5+1		30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAPET. OF DEATN (ITEM 27) (Type, Print) Bala Duggirala, MD 9600 North Pt. Road Fort	Howard, MD 21052
		MAY 2 3 1995 Julia Place Strange Signature	



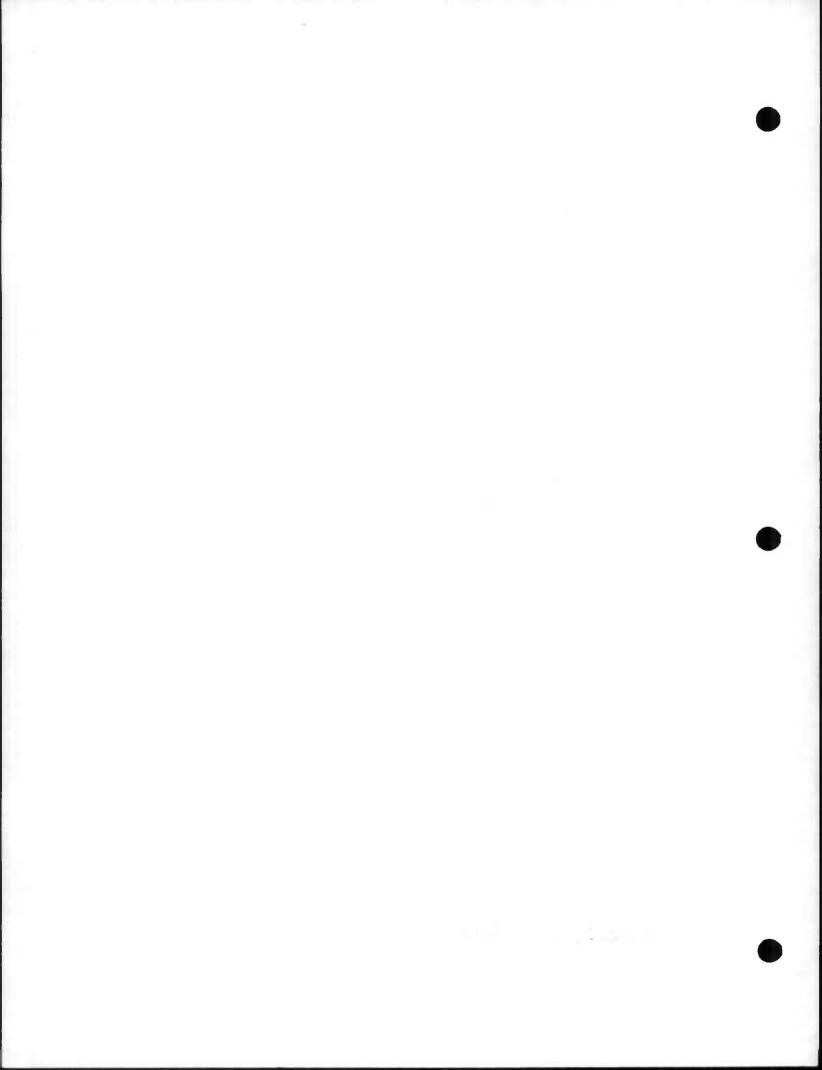
		FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEI		
		1. DECEDENT'S NAME (First, Middle, L	ast)				2. DATE OF DEATH	DAYYEAR	3. TIME OF DEATH
		Helen 4. SOCIAL SECURITY NUMBER	Mil]				May 17,	, 1995	1850 pm m
pino		218-05-4303 9e. FACILITY NAME (If not inatitution, s	1 M 2 🕸 F	(In yrs. last birthday)	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 27	7, 1913	MD
1, 2, 3 should	DIRECTOR	Northwest Hosp	oital Center	or Location of D		9c. COUNTY OF DEATH Baltimore			
Pages	REC	10a. STATE 10b. CO		10c, Cl	TY, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
permit. P		MD Bo	altimore		Baltim	r. ZIP CODE		Last commence	1 - YES 2 1 NO
st.	ERA	8209 Arrowhead	a Poad		10	21208		US	WHAT COUNTRY?
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 E NO	If yes, as	CENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	ea or No — 14. RA Bla	CE — American Indian, ack, White, atc.
1215-0 r attending use as the	ETED	15. DECEDENT'S (Specify only highest s	EDUCATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b, KIND OF BU	USINESS/INDUSTRY	White
212 fall or us	틸	Elementary/Secondary (0-12)	College (1-4 or 5+)	#fe. Do NOT L		ost of working			
IARYLAND 2- rained by the hospital or should be detached for titfled at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Leat	1	HOU	sewife	14 MOTHERIS N		Home	
YLA by the be deta	ū.		uels				AME (First, Middle, Maide) Ca Fine	n Surname)	
MAR retained 5 should notified	10 8	19a. INFORMANT'S NAME (Type/Print)		- {			Route Number, City or To		
RE, No lay be re page 5	-	Mr. Barry Mil					imore, MD		
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		20a. METHOD OF DISPOSITION 2 Buriel 2 Cremetion 3 4 4 Donation 8 Other (Specify)	Ramoval from State		of disposition (Nother place). KOV Beth		5-19-199	ocation – chy or 5 Baltin	Town, State
BALTIMOF after death. Page 6 m by the funeral director, emoval.		21. SIGNATURE OF FUNERAL SERVICE		A .	22. NAME A	ND ADDRESS OF FA	ACILITY		IOLC TID
SAL r death		· Areth	M. Cutte	10			SON & BROS.		MORE, MD 212
hin 24 hours reely filled in b mation, or rer ft, the medi		23. PART I. Enter the diseases, shock, or hast failt IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Sur Barrana	AACH	NOD	HEI	to CRH	AGE	Approximata Interval Between Onset and Death
P.O. BOX 68: h certificate be execute anding physician and or Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	OF):	ANEL	1 R YSM	1	
the death by the attended Mental Hijury, or	AL C	PART II. Other significant cond	itions contributing to death b	ut not reaulting	in the underlyin	g ceuse given in	Part i. 24e. WAS AI		b. WERE AUTOPSY FINDINGS
Signed by Health an was any	: MEDICA	DID TODAGGO UGE GO					1 _ YES	PRMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MINO
AL has has Dept	AN	DID TOBACCO USE CO			ES LI NO L	UNCERTAI	ИМ		
F VITA SICIAN: The certificate the State t, or Item	PHYSICIAN	EXAMINER? 1 YES 2 NO	HOSPITAL:	etlent 3 DOA	OTHER:	te 5 🗆 Residence	8 Other (Specify)		
O 돌 돌 를	BY PH	27. MANNER OF DEATH Neturel 5 Pending 2 Accident Investigate	28a. DATE OF INJURY (Month, Day, Year)	28b. Til	JURY WO	URY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURED	
TTENOI TTENOI TTOR: A after da	ETED !	3 Suicide 8 Could not 4 Homicide determine		— At home, farm,	street, tectory, offic		28t. LOCATION (Street City or Town, State		Route Number,
425	COMPLE		HYSICIAN: To the best of my knowledge. WINER: On the basis of examination						(a) and manner as stated.
TO THE HOSPITE TO THE FUNERA DE filed within 7 IMPORTANT: 1	BE	29b. SIGNATURE AND TITLE OF CERT	IFIER Aux	Ilip		29c. LICENSE NU	7333	29d. DATE SIGNE	D (Month, Day, Year)
10	5	30, NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type		TO. M	02113	3	1 4 4
		MAY 2 3 1995	12: REGISTRAR'S SIGN	ATURE					



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within Extract death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
V TO THE HOSPITAL (TO THE FUNERAL DE filed within 72 h	IMPORTANT: If I

1 - FOR STATE REGISTRAR	STATE OF MARYL		ATE OF I	DEATH		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Lat ALEXANDER	" MOORE	OEITH IC	ALE OF L	DEATH	2. DATE OF		GGS.	5:00P
4. SOCIAL SECURITY NUMBER 214-56-0084	5. SEX 6. AGE	(In yrs. lest birthday) I	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, L	BIRTN	Count	NPLACE (State or Foreign n) Vland	
90. FACILITY NAME (If not institution, gh.	,						NA	
10e. STATE 10b. COU	NA	16c. CITY, 1		imore	City			10d. INSIDE CITY LIMITS? YES 2 NO
1503 Ensor St			101. 2	2120	1	10g. Cl	USA	WNAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 X NO	If yes, spec	NDENT OF HISPAN offy Cuban, Mexica NO Specifi	n, Puerto Ric	Specify Yea or No— an, etc.)	14. RACE Black Speci	E — American Indian, k, White, etc.
15. DECEDENT'S E (Specify only highest gri Elementary/Secondery (0-12)	College (1-4 or 5+)	Iffe. Do NOT use n	k done during most etired.)	of working	16b. K	IND OF BUSINESS/IN		
17. FATHER'S NAME (First, Middle, Last)	NA NA	Lands				Landsca	-	5
Alexander Jun	uis Moore	19b. MAILING AD		Mary E		Moore City or Town, State, Z	(ip Code)	
Jean Sherrod	1	508 E	. 26th	St. B	alto,	MD 212	201	
N□NBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) _	emovat from State	b. PLACEANDDATE OF I metery, cremetory or other acred Head	rt Cemet	ery 5/	22/95	Dundalk	Cify or To	own, State
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME AND	ADDRESS OF FA	CHITY			
J.C. [1	GWell In		Unit	y Fune:	ral H	70 Ral	to.	MD 21201
iMMEDIATE CAUSE (Final disesse or condition	e. List Dnly Dne Cause Dn a	nach ilne.	Unit	y Fune:	ral H	70 Ral	to,	Approximsta interval Between Onset and Dasti
iMMEDIATE CAUSE (Final disease or condition resulting in death)	s. Prevalent of the control of the c	A CONSEQUENCE OF):	Unity 108	y Fune W. Nor	ral H	70 Ral	rrest,	Approximsta interval Between Onset and Dasti
iMMEDIATE CAUSE (Final disease or condition	s. Pre-	A CONSCOUENCE OF:	Unity 108	y Fune W. Nor	ral H	70 Ral	rrest,	Approximate interval Between Onset and Dasti
iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	B. List Daily Date Cause Dri a DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d.	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	Unity 108 anter the mode	y Fune. W. Nor. s of dying, such	ral H th Av h as cardia	70 Ral	rrest,	Approximate interval Between Onset and Dast Zuworth
IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the condition of the condition of the cause of the caus	B. List Daily Dae Cause Da a DUE TO (OR AS a DUE TO (OR AS a DUE TO (OR AS a d. Days contributing to death it	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the consequence of the cons	Unity 108 anter the mode	y Fune. W. Nor. s of dying, such	ral H th Av h as cardla	7 e . Bal c or respiratory and control of the contr	rrest,	Approximata interval Between Onset and Dasti Zuwowtw. 10 Years WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inlited events resulting in death) LAST	B. List Daily Dae Cause Da a DUE TO (OR AS a DUE TO (OR AS a DUE TO (OR AS a d. Days contributing to death it	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not reaulting in the consequence of the cons	Unity 108 anter the mode Cect (Check only one) THER:	y Fune. W. Nor. e of dying, such	ral H th Av h as cardia	Te. Bal c or respiratory as as. was an autopsy performed? yes 2 1 No	rrest,	Approximata interval Between Onset and Dasti Zuvovatu IO Yawa IIO
IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the cause of th	DUE TO (OR AS DU	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not reaulting in the consequence of the cons	Unity 108 anter the mode Cect (Check only one) THER: Hursing Home FF 28c. INJUR WORK	y Fune. W. Nor. e of dying, such Cause given in UNCERTAIN 5 Residence	Part I. 2	Te. Bal c or respiratory as as. was an autopsy performed? yes 2 1 No	246	Approximata interval Between Onset and Dasti Zuvovatu. I O Yews. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLY/ING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the cause of the condition of the cause o	DUE TO (OR AS DU	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the consequence of the cons	Unity 108 anter the mode Cect (Check only one) THER: Hursing Home FF 28c. INJUR WORK 1 YES	y Fune. W. Nor e of dying, such	Part I. 24 N D S Other (S 28d, DESCR	Te. Bal c or respiratory and control of the control	24b.	Approximate interval Between Onset and Dast Zurovith IO Yours WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other algnificant conditions or injury that initisted events resulting in death) LAST PART II. Other algnificant conditions or injury that initisted events resulting in death) LAST PART II. Other algnificant conditions or injury that initisted events resulting in death) LAST PART II. Other algnificant conditions or injury that initisted events resulting in death injury that initisted events or injury that initisted events resulting in death injury that	DUE TO (OR AS DU	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the consequence of the cons	Unity 108 anter the mode Cleck only one) THER: Mursing Home F 28c. INJUR WORK 1 YES et, tactory, office	y Fune. W. Nor. e of dying, such Cause given in UNCERTAIN 5 Residence AY AT S 2 No	Part i. 24 N Other (S 28d. DESCR	Te. Bal c or respiratory as As. Was an autopsy PERFORMED? YES 2 NO Specify) HIBE NOW INJURY OC ON (Street and Number Town, State)	24b.	Approximate interval Between Onset and Dast Zurovith IO Years WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are suiting in death) LAST DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 400 27. MANNER OF DEATN 1 Natural 5 Pending Investigation investigation determined 29 CERTIFIER (Check only one) 2 MEDICAL EXAMINERS 29b. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 1 MEDICAL EXAMINERS (Check only one) 2 MEDICAL EXAMINERS (Check only one) 1 MEDICAL EXAM	DUE TO (OR AS DU	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the consequence of the cons	Unity 108 anter the mode Check only one) THER: Hursing Home WORK 1 VE: et, tectory, office at the time, date are in my opinion, dear	y Fune. W. Nor. e of dying, such Cause given in UNCERTAIN 5 Residence AY AT S 2 No	Part i. 24 Part i. 24 S Other (S 28d, DESCR	Te. Bal c or respiratory as ta. WAS AN AUTOPSY PERFORMED? YES 2 NO ON (Street and Number flown, State)	24b.	Approximata interval Between Onset and Dasti Zuvovatu IO YZOUS WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO



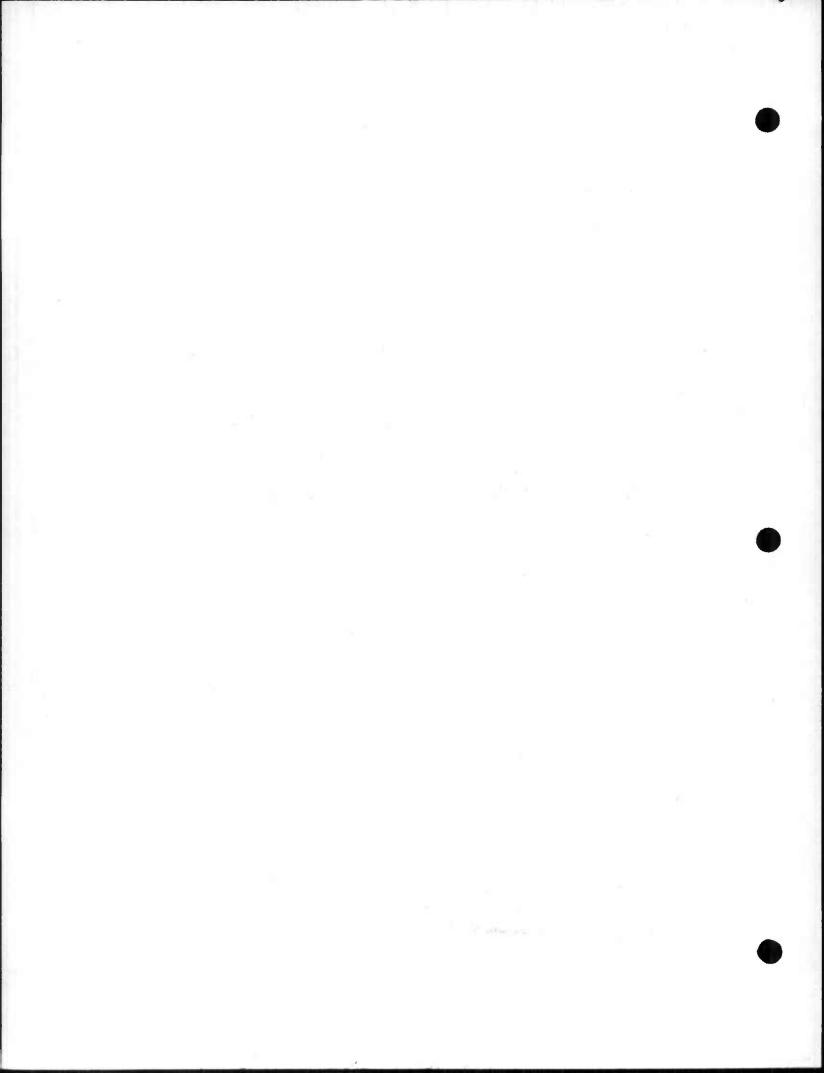
ITEMS: 23 PART I, II, 27, PER MEO FILM G-724 6/5/95 t.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

	FOR 1 - STATE REGISTRAR		MARYLAND /	DEPAR	TMEN	T OF H	_	D MEI	NTAL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last) SAMMIE						LOGH		REG. NO DATE OF DEATH		-VEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)		R 1 YEAR	IF UNDER 24 HR	s. 7. I	DATE OF BIRTH (Month, Day, Ybar)			CE (State or Foreign
	216 52 0424 9e. FACILITY NAME (If not inelitation, give et		46	Tha.					02 04		Mary]	
DIRECTOR	2119 DUKELAND S						MORE	F DEATN		9c. COUNTY OF DEATH NA		
<u>D</u>	10a. STATE 10b. COUNTY	,		10c. CITY	, TOWH	OR LOCAT	TION				140	I. INSIDE CITY
	Maryland 100. STREET AND NUMBER	NA					Baltin	nore	City		1)	LIMITS? YES 2 NO
FUNERAL		_				101	. ZIP CODE			10g. CITI2	EN OF WHAT	COUNTRY?
N N	2119 N. Dukela						212				USA	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT OF HIS	PANIC O	RIGIN? (Specify Yes	or No-	14. RACE — A Black, WI	American Indian,
≥	3 Widowed 4 Divorced	IF YES, GIVE Y				1 YES	2 NO Sp	ecity:	orto riicari, etc.;		Specify:	
	15. DECEDENT'S EDUC	2471041										Black
COMPLETED	(Specify only highest grade	completed)	(G	CEDENT'S	rork done	during mo	ON est of working		16b. KIND OF BUI	SINESS/INDU	USTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5	+) #16.	Do NOT us								
g \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	17. FATNER'S NAME (First, Middle, Lest)	NA		P	ort	er					nance	
							The State of		First, Middle, Malden	,		
BE	John McCullough	<u>a</u>							Smith			
TO BE	19a. INFORMANT'S NAME (Type/Print)	_							Number, City or Tow		,	
9	Mylinda McCullo			<u> 2119</u>	N.	Du.	keland	St	. Balt			
15 I	20e. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Remo	oval from State	20b. PLACE A				nme of	1	1		ity or Town,	
	4 Donation S Other (Specify)		Mt.	Zion	Ce	mete	ery	5/12	.6/95 B	alti	more,	MD
	21. BIGNATURE OF FUNERAL SERVICE LICE	1 / / P			22. T.T	NAME AN	y Fune	FACILIT	Υ			
	DI Z. HARW.	es, (h			1	UO I	y rune	Tai	Ave.	D = 1 +	- MD	21201
2	23. PART I. Enter the diseases, or co	omplications the	t caused the de	ath. Do n	ot enter	the mo	da of dving, 1	uch ea	cerdiac or readi	Dall	o, ML	Approximata
	anock, or neert fellure. L	list only one ceu	ise on each ilne							tatory unit	(200)	interval Between
5	IMMEDIATE CAUSE (Final disease or condition	FATTY L	TVER									Onset and Death
É	resulting in death)		(OR AS A CONSEC	NIENCE OF	3.							
5		502 10	(ON AS A CONSEC	OENCE OF	F							
CERTIFICATION	Sequentielly list conditions,	OUE TO	(OR AS A CONSEC	NIENCE OF								
A	If any, leeding to immediate cause. Enter UNDERLYING	340.13	TON NO M GONDEC	OENOL OF	,-						i	
	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEC	UENCE OF):							
E	resulting in deeth) LAST				,-						i	
		14									i	
占	PART II. Other aignificent conditions		death but not r	esuiting in	n the ur	nderlying	ceuse given	In Part	i. 24a. WAS AN			E AUTOPSY FINDINGS
MEDICA	MYOCARDIAL FIBROSIS	S							1 YES 2		CON	LABLE PRIOR TO IPLETION OF CAUSE
ij									1	_ NO		DEATH?
	DID TOBACCO USE CONTR	IBLITE TO CA	USE OF DEA	TH YE	ς Π I	NO F	UNCERT	AINI I	- I		'-	YES 2 NO
<u>₹</u>	25. WAS CASE REFERRED TO MEDICAL	DOTE TO CA		E OF DEAT			DIACEKIA	All V				
S	EXAMINER?	HOSPITAL:			OTHE	n.	У					
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF		28b, TIME			5 ARealden	-				
	1)(X) Naturel 5 Pending	(Month, D.		INJU			RK?	280	OESCRIBE NOW I	NJURY OCCI	URED	
ВУ	2 Accident Investigation	28a PLACE O	F INJURY At hor	4			ES 2 NO	-				
E C	3 Suicide 6 Could not be 4 Homicide determined	building,	atc. (Specify)	ne, term, st	rest, ract	iory, office		28f.	City or Town, State)	ind Number o	or Rural Route	Number,
i ii	an official											
COMPLETED	29a, CERTIFIER (Check only one)											
Ö	2 MEDICAL EXAMINER	: On the basis of er	ramination and/or l	rvestigation	, In my c	opinion, de	eath occured at t	the time,	data and place, sn	d due to the	couse(a) and	manner se stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	7,20	11				29c. LICENSE I	UMBER		29d. DATE	SIGNED (Mon	ith, Day, Year)
BI	T. Verokon	11.9	Kend		0	İ	O.C.M	. E.			Y 22,	
1 2	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED SALV	e or previous		-		0.0.1				/	

LETEO CAUSE OF DEATH THE STITLES OF STREET, BALTIMORE, MARYLAND



DIVISION OF VITAL RECORDS, P.O. BOX 68760

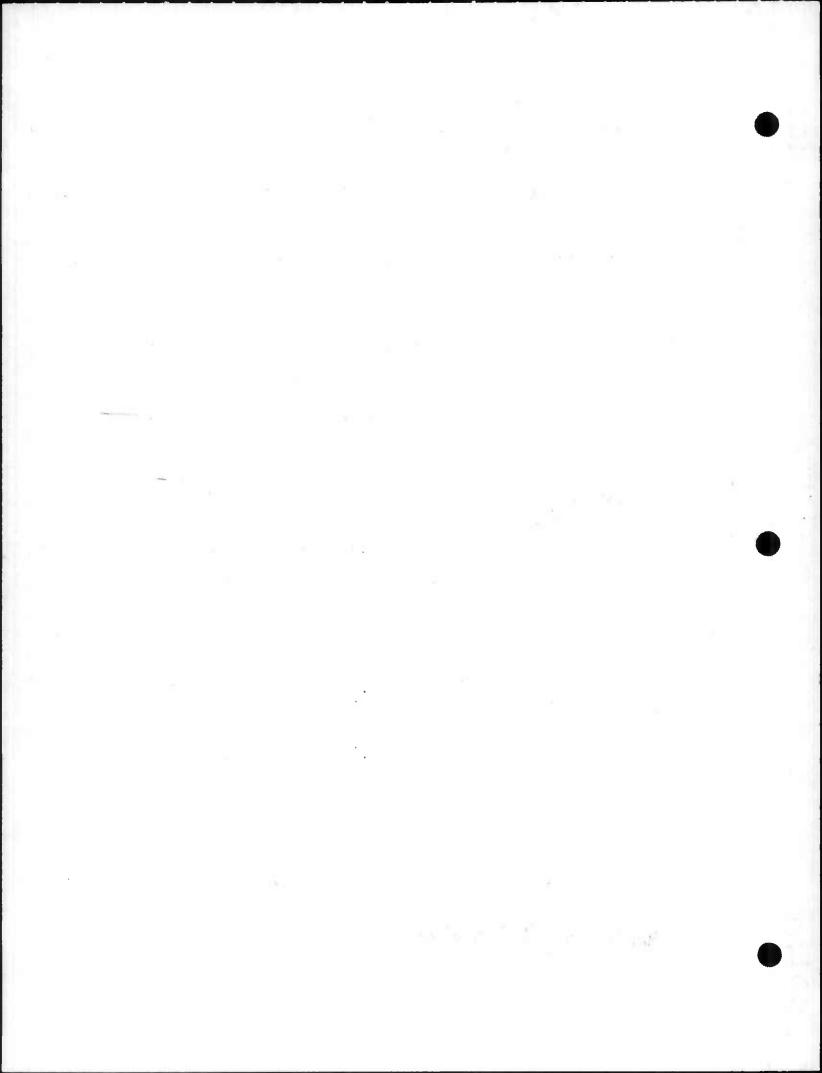
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CATE OF			REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DEATH		W. a.	3. TIME OF DEATH	
	NAOMI	MARY			MARSH	A L L	1	MAY 14	1	995	9:30	p_{M}
i	140 10 1447	M 2 TF	3. AGE (In yrs. last bit		F UNDER 1 YEAR	IF UNDER 2 HOURS	MIN. T	May 15, 1	921	8. BIRTH Countr	PLACE (State or Foreign) PA	gn
	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF										EATH	
DIRECTOR	GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMO											
		gomery	1		tboro	TION					10d. INSIDE CITY LIMITS? 1 YES 2 NO	0
FUNERAL	345 County Line I	Road			10	1904	0		10g. CIT	US.	/HAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	EVER IN U.S. ARMEI YES 2 NO R OR DATES	D	If yes, sp	ENDENT OF ecity Cuben, 2 10 NO	Mexican, P	ORIGIN? (Specify Yes tuerto Rican, etc.)	or No-	14. PIACE Black Speci	- American Indian, t, White, etc. y: white	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	TON impleted) College (1-4 or 6+)	(Give I life. Do	kind of wo	SUAL OCCUPATION done during more retired.)	ON ast of working		16b. KIND OF BUS	Hom:		wiite	
Ž.	17. FATHER'S NAME (First, Middle, Lest)		1	Tome	maker					е		
BE CC	George F. Koehler							(First, Middle, Maiden Lna Seipp				
2	19e. INFORMANT'S NAME (Type/Print)		19b. M	IAILING A	DDRESS (Street	nd Number o	r Rural Rout	Number, City or Town	n, State, Zip	Code)		
-	Deborah J. Miller		20	001	Sunrise	Way,	Jami	ison, Pa	1892	9		
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remova 4 Donation 6 Other (Specify)	I from State	20b. PLACE AND cemetery, cremete IVV HI	DATE OF	DISPOSITION (No	me of	y 19	DATE 20c LOC ,95 Phil	cation –	City or To	wn, State	
	21. SIGNATURE OF FUNERIAL SERVICE LICEN	SEE,			22. NAME AI	ID ADDRESS	OF FACILI	TY				
	+ Hulles X	Harle		-	STERL 736 E	ING A	SON	FUNERAL	HOM	E, II	NC.	
	23. PART I. Enter the diseases, or com shock, or heart fallure. Lis	plications that	sused the death	. Do no	t enter the mo	de of dyln	g, such se	s cardiac or reapi	ratory sn	rest,	Approximats	
	IMMEDIATE CAUSE (Fins)	META	STATIC OR AS A CONSEQUE			CA	W(ER			Interval Betwonset and D	sath
NO	Sequentially list conditions, if any, leading to immediate		R AS A CONSEQUE									
ERTIFICATI	cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST	DUE TO (O	R AS A CONSEQUE	NCE OF):								
L CERTIFICATION	CAUSE (Disesse or injury that initisted events resulting in death) LAST					A CRIME OF	en la Bar	at I are uneau	ALSTORAV			
DICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	ontributing to d	esth but not resu	alting in	the underlyin	D H	ven in Par	1 24e, WAS AN. PERFOR	MED?	24b.	WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	5.5
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	contributing to d	esth but not resu	alting in	the underlyin	DA		PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUS	5.5
MEDICAL	CAUSE (Disease or injury that initiated events resulting in desth) LAST PART II. Other significant conditions of the co	SONTHIBUTING to do	POPR	alting in	the underlyin	DA	ven in Par	PERFOR	MED?	246.	AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	5.5
MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU	POPR	YES	ths underlying	D H	RTAIN [PERFOR	MED?	24b.	AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	5.5
PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU	SE OF DEATH 26. PLACE O SR/Outpetlent 3 □ 1 JURY 2	YES	the underlying NO [(Check only one) THER: Nursing Hom OFF 28c. INJ.	D A	RTAIN [PERFOR	MED?		AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	5.5
BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU OSPITAL: Vinpetient 2 E8. DATE OF IN (Month, Day,	SE OF DEATH 26. PLACE O ER/Outpatlent 3 1 JURY Yeer) NJURY — A1 home.	YES PF DEATH DOA 4 Bb. TIME (INJUR	the underlying NO [(Check only one) THER: Nursing Hom OFF 28c. INJ W 01 1	UNCE o 5 Real URY AT RK? YES 2	RTAIN [dence 5 284	PERFOR 1 VES 2 Other (Specify) d. DESCRIBE HOW IN	MED?	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	5.5
BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU OSPITAL: (Vinpetient 2 = E 266. DATE OF IN (Month, Dec.)	SE OF DEATH 26. PLACE O ER/Outpatlent 3 1 JURY Yeer) NJURY — A1 home.	YES PF DEATH DOA 4 Bb. TIME (INJUR	the underlying NO [(Check only one) THER: Nursing Hom OFF 28c. INJ W 01 1	UNCE o 5 Real URY AT RK? YES 2	RTAIN [dence 5 284	PERFOR 1 VES 2 Other (Specify)	MED?	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	9.55
BY PHYSICIAN: MEDICAL	CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU OSFITAL: Vinpetient 2 = E 26e. DATE OF Indiding, etc. N: To the best of my	SE OF DEATH 26. PLACE O ER/Outpetlent 3 1 JURY 24 NJURY — A1 home, c. (Specify) y knowledge, death	YES OF DEATH DOA 4 6b. TIME (INJUF)	The underlying A	UNCE • 5 Reel • TRY (ES 2 • and place, e	RTAIN (dence 6 284 NO 266	PERFOR 1 VES 2 Other (Specify) d. DESCRIBE HOW IN 1. LOCATION (Street e. City or Town, Stele) the ceuse(s) and men	MED?	CURED or Aurel A	AMALABLE PRIOR TO COMPLETION OF CAURO OF DEATH? 1 YES 2 NO	38
BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disesse or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SUTE TO CAU OSFITAL: Vinpetient 2 = E 26e. DATE OF Indiding, etc. N: To the best of my	SE OF DEATH 26. PLACE O ER/Outpetlent 3 1 JURY 24 NJURY — A1 home, c. (Specify) y knowledge, death	YES OF DEATH DOA 4 6b. TIME (INJUF)	The underlying A	UNCE 5 Rest UNTY AT RKY (ES 2 end place, e eseth occurred	RTAIN (dence 6 284 NO 266	PERFOR 1 VES 2 Other (Specify) d. DESCRIBE HOW IN 1. LOCATION (Street e. City or Town, Stete) he cause(s) end men. e, date end place, end	NJURY OCC	CURED or Rural R led.	AMALABLE PRIOR TO COMPLETION OF CAURO OF DEATH? 1 YES 2 NO	38
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the co	SONTIFICATION OF THE PROPERTY	SE OF DEATH 26. PLACE O ER/Outpetlent 3 10 10 10 10 10 10 10	YES OF DEATH DOA 4 68b. TIME (INJUE) form, street	the underlying A	UNCE 5 Real URY AT RK? FES 2 end place, e enth occurred 29c. LICEN	RTAIN (dence 6 28- NO 26- and due to 11 at the time	PERFOR 1 VES 2 Other (Specify) d. DESCRIBE HOW IN 1. LOCATION (Street e. City or Town, Stete) he cause(s) end men. e, date end place, end	NJURY Occurred Number	CURED or Rural R led.	AMALABLE PRIOR TO COMPLETION OF CAIR OF DEATH? 1 YES 2 NO oute Number,	38

DIVISION OF VITAL RECORDS P.O. BOX 68760

		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) IRENE, ANNA MATTHEWS 2. DATE OF GEATH MONTH DAY YEAR 3. TIME OF DEATH MONTH DAY 15 1995 11:15 AM
9		4. SOCIAL SECURITY NUMBER 217-14-1925 5. SEX 1
2. 3 should	TOR	NOrth Arundel Hospital Glen Burnie Anne Arundel RESIDENCE OF DECEDENT
t. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Essex 1 □ YES 2 ☑ NO
nsit permit.	FUNERAL	10a. STREET AND NUMBER 421 Margaret Avenue 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States
ing physician. the burial-transit	BY	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO Specify: 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No- Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- Black, White, etc.) 16. YES, GIVE WAR OR DATES 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- Black, White, etc.) 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- Black, White, etc.) 19. Was December of Hispanic Origin? (Specify Yea or No- Black, White, etc.) 19. Was December of Hispanic Origin? (Specify Yea or No- Black, White, etc.) 10. Was December of Hispanic Origin? (Specify Yea or No- Black, White, etc.)
hospital or attending ached for use as the	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.) HOMEMAKET 16b. KIND OF BUSINESS/INDUSTRY OWN HOME
be det	BE COMPL	17. FATHER'S NAME (First, Middle, Last) George Schwartz 16. MOTHER'S NAME (First, Middle, Meiden Surname) Mabel Collison
y be retained I age 5 should be notified	10	Mr. Harry E. Matthews, Jr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 230 Obrecht Road Millersville, MD. 21221 21108
e 6 mar		20s. METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Removal from State 4 Donation 6 Donation 5 Donation 5 Donation 6 Don
death. e funera		22. NAME AND ADDRESS OF FACILITY MC Cully Funeral Home of Pasadena 3204 Mountain Rd. Pasadena, MD. 21122
ficate be executed within 25 hours after the physician and completely filled in by the physician burial, cremation, or removal to the prior to burial, cremation, the medical set traumatic event, the medical	CATION	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):
th certifical ending phy il Hygiene p or other	CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF): d
The law requires that the death are has been signed by the atter are Dept. of Health and Mental em 23 shows any injury, o	MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIA FISHILLATION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 24a. WAS AN AUTOPSY PINDINGS ANALIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check poly one)
E 88 5	/SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO NO NO NO NO NO NO NO NO
PHY start with the start of the	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 280. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO
OR ATTENDING DIRECTOR: After hours after death item 28 is ma		3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, tarm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
3 3 Z =	COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(s) and menner as stated.
TO THE HOSPI TO THE FUNEF De filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) MAY 15 95 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
6		PRYDEN OKETHOT. NAIL. 301 HOZE DEVE GLEN BURNE MD 21061 MAY 23 1995 Jahr Dimberhard



Pages 1, 2, 3 should

permit.

page 5 should be detached for use as the burial-transit

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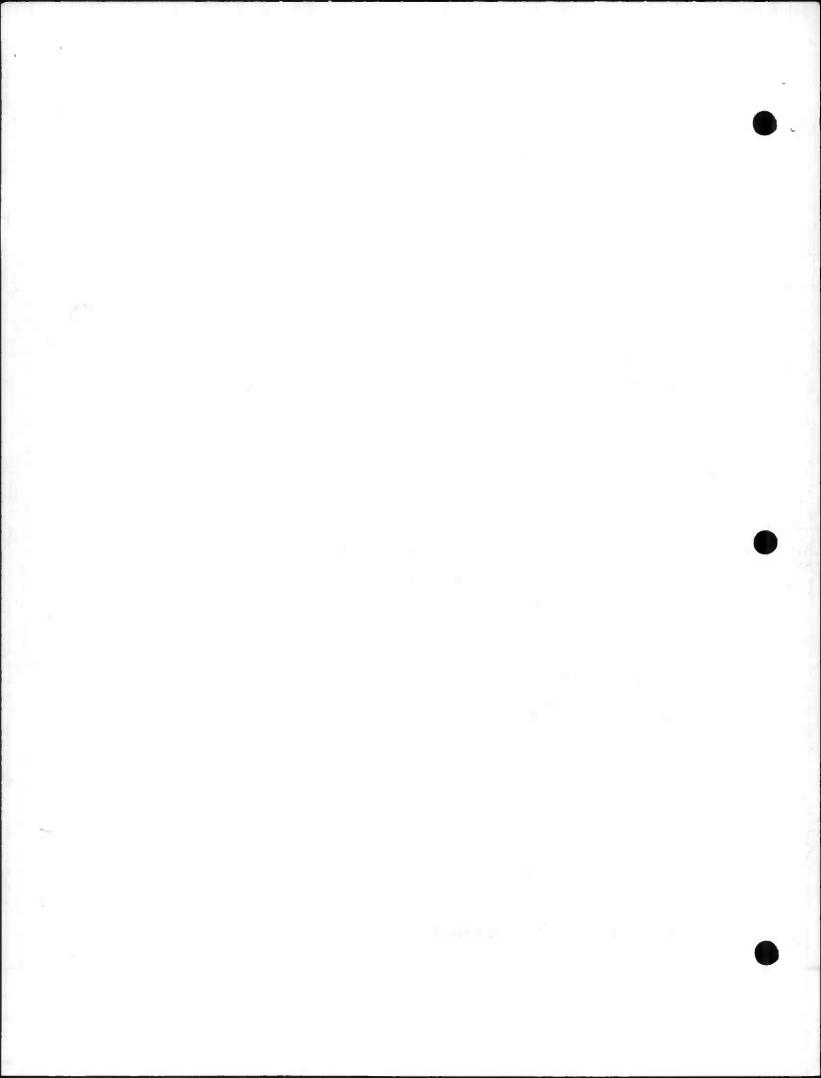
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DIVISION OF VITAL RECORDS, P.O.	The OD ATTRACTOR CONCENTRAL The last enemies that death medificate he seconded with
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH Watthew Witchell May 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH April 28 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) 247-20-1833 1 M 2 F DAYS HOURS 80 1915 South Carolina 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Mercy Medical Baltimore Center Balto. City RESIDENCE OF DECEDEN Baltimore City 10a. STATE 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY MO Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? 334 Edmonson AVL. 21229 United States 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, etc.)
1 UYES 2 ND Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Retired City of Baltimore 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hampton Mitchell to Ida Gayle Mitchell BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gladys Mitchell 3314 Edmondson Ave. Balto. Md 21229 9 20a. METHOD OF DISPOSITION
12 Burial 2 Cremetion 3 Ramoval from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must Loudon Park Cemetery 5/25/95 Baltimore, Maryland examiner 22. NAME AND ADDRESS OF FACILITY Estep Bros. Funeral Home P.A. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1300 Eutaw Place Balto. MD 21217 medical 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final the disease or condition CONGESTIVE HEART Failure
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) or other traumatic event, CO TOWARY GATERY & disease CERTIFICATION Sequentieily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST Injury. PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? right upper lobe lung mass, prostate cancer any 1 YES 2 NO Shows passive congestion 1 [YES 2 [ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 ND 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER DF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending investigation 1 YES 2 ND BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) 60 8 Could not be COMPLETED 4 Homicide 28 ltem. 29a. CERTIFIER
(Chack ank)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 HORITANT: If IN 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Ichard Chen DID Medical Resident > 5/19/95 P66865 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S. Greene St., Medicine, Baltimore, LO PRESISTRAR SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



Pages 1, 2, 3 should

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CERTIFICATION

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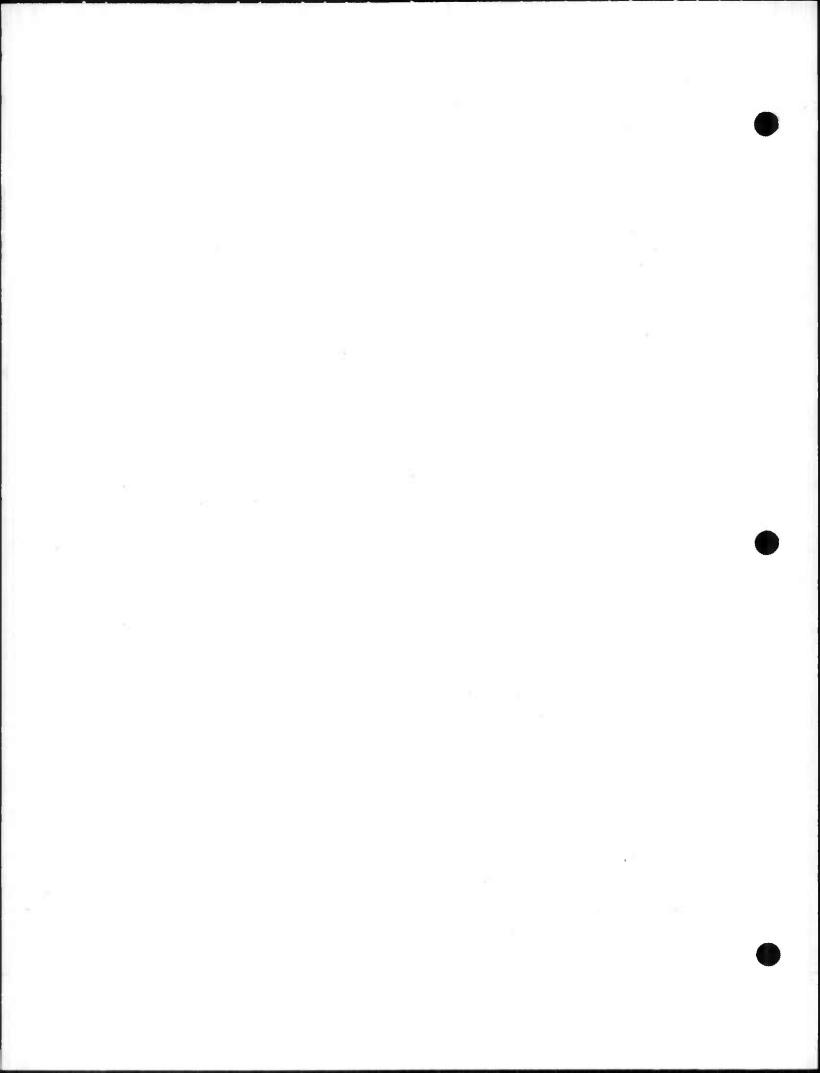
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 8:20 P Charles Leroy Murphy May 18,1995 4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 7, 1915 IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 212-01-5947 1 M 2 - F 80 YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 5943 Loreley Beach Road White Marsh Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore White Marsh 1 YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5943 Loreley Beach Road 21162 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 7 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elemeritary/Secondary (0-12) College (1-4 or 5+) Parks&Recreation Balitmore County 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harry Murphy Minnie Hylander 19a. INFORMANT'S NAME (Type/Print, 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5943 Loreley Beach Road White Marsh Md. 21162 Joan Wright 20a. METHOD OF DISPOSITION
1 State | 2 Cremetton 3 Ramoval from State | 4 Donatton 5 Ramoval from State | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Page | 1 Pag 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Donation 5 Other (Specify) Holly Hill Cemetery 5/22/95 Baltimore Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY Connelly Funeral HOme of Essex 300 Mace Ave. Baltimore Md. 21221 23. PART I. Enter the diseases, or c complications that caused the chart. Do not enter the mode of dying, such as cardiec or respiratory arrest, List only one cause on each line. Approximata shock, or heart failure. intarvai Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition CARCINOMA OF THE ~ 9 mos resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reautiling in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO ATHEROSCLERATIC CAPDIOYASCULAR DISCRIFE COMPLETION OF CAUSE 1 - YES 2 1 NO OF DEATH? DAPETES MELLITUS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Nesidence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 _ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mopth, Day, Year) 0150 22 CAUSE OF DEATH (ITEM 27) (Type, Print)

WD; 8552 PHILADELPHIA RU, DRESS OF PERSON WHO COMPLETED



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOX 68760 o DIVISION OF VITAL RECORDS, P.

STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MaçAleese 3. TIME OF DEATH dA May 00:00 PM 4. SOCIAL SECURITY NUMBER S SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 013-03-2666 May 25, 1908 Canada 1 M 2 X F 86 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH St. Agnes Hospital DIRECTOR **Baltimore** N/A RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 TES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Reath and Mental Hygiene prior to burial, cremation, or removal. 6117 Northdale Road 21228 U.S.A retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: White BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) COMPL Hostess Restaurant. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robie Harvie 듆 Priscilla Sanford BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara Andresky 6107 Northdale Road Catonsville, Maryland 21228 hours after death. Page 6 may be Pe 20sc METHOD OF DISPOSITION
1 D Burlel 2 D Cremetion 3 D Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must St. Johns Cemetery May 23, 1995 4 Donation 8 D Other (Specify) Ellicott City, Maryland examiner 21. SIGNATURE OF FUNDAME SERVICE LICENSES 22. NAME AND AODRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home ussellan 1630 Edmondson Avenue Catonsville, Maryland 21228 the medical 23. PART t. Enter the diseases, or complications that beused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finei **Onset and Death** disease or condition Masseus muy event, reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially jist conditions. OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not reaulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? MI A arte any Cenages 1 YES 2 NO guigo 1 TES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN T has b. Oept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h the State HOSPITAL: OTHER: 1 TYES 2 NO OR ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending 1 YES 2 NO BY After death 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, lerm, street, lectory, office building, stc. (Specify) 28 Is 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) DIRECTOR: / COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the ilms, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DIVOUL DMAY 19 2 30. NAME AND ADDRESS OF PERSON WHO COMPUTED CAUSE OF DEATH (ITEM 27) (Type, Print) AGNES HOSP(TAT 31. DATE FILED (Month, Del. Sar) AGGISTRAR'S SIGNATURO

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9c. COUNTY OF DEATH

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10g, CITIZEN OF WHAT COUNTRY?

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

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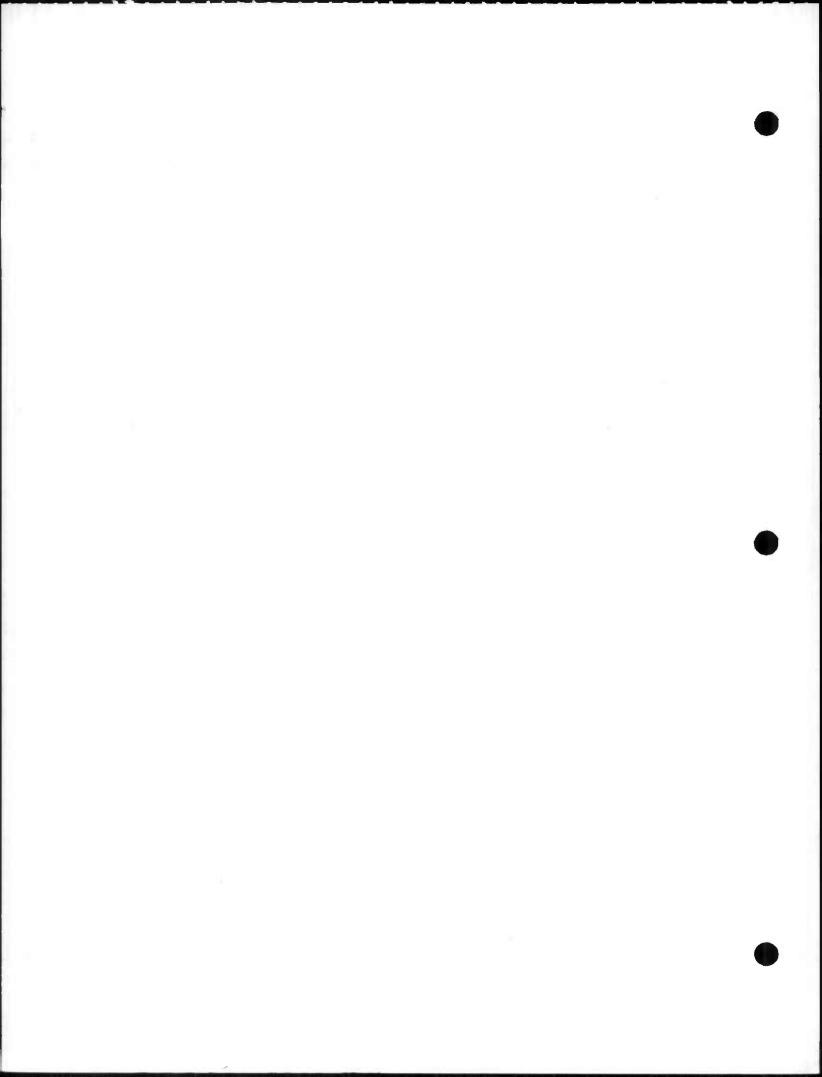
and completely filled in by the funeral director, page 5 should be detached for executed within death certificate be TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law in TO THE FUNERAL DIRECTOR: After this certificate has be be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 s

DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH HUNDUD 141/81 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. last birthday) 7. DATE OF BII (Month, Day, IF UNDER 1 YEAR 15-46-8 1 M 2 - F MONTHS DAYS HOURS MIN 6.5 YRS B 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH LIBERTI MEDI DIRECTOR permit. Pages 1, 2, 3 : 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARILAND 10. STREET AND NUMBER FUNERAL 10f. ZIP CODE 0 N use as the burial-transit STREE Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED ORCES? 1 YES 2
YES, GIVE WAR OR DATES FORCES? 2 NO 1 Never Married 2 Merried 1 YES 2 NO Specify: BY 3 Wildowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade cor (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 2+HGR COMPL ADE ROOM NORKER SEA be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Midde P 0 S BE 19s. INFORMANT'S NAME (Type/Print) 9h. MAILING ADDRESS (Street and Number 2 20s. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20h PLACE AND DATE OF DISPOSITION (Name of must medicai examiner 21. SIGHATURE OF FUNERAL SERVICE LICENSES 22. HAME AND ADDRESS OF FACILITY JOSEPH H, BROWN 3 23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart fallura. Liet only one ceuse on each line. ŏ IMMEDIATE CAUSE (Finel 0 cremation, other traumatic event, the mmynode disease or condition_ nived reculting in death) DUE TO (OR AS A CONSEQUENCE OF) burial, CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): prior to If sny, laeding to immediata cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 0 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL DIRECTOR; After this certificate has been hours after death with the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \Boxed NO \Boxed UNCERTAIN [PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) HOSPITAL 1 Inpatient OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 1 Natural Pending 1 YES 2 NO BΥ Accident nveatigation 3 🗌 Suicide COMPLETED 6 Could not be 4 Homicide datarmined

Approximate Interval Between Onsat and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TES 2 NO 28d. DESCRIBE HOW INJURY OCCUREO 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. AND JITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) Day, PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IMORE 32 REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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filled in by the funeral director, page 5 should be detached for use as the burial-transit

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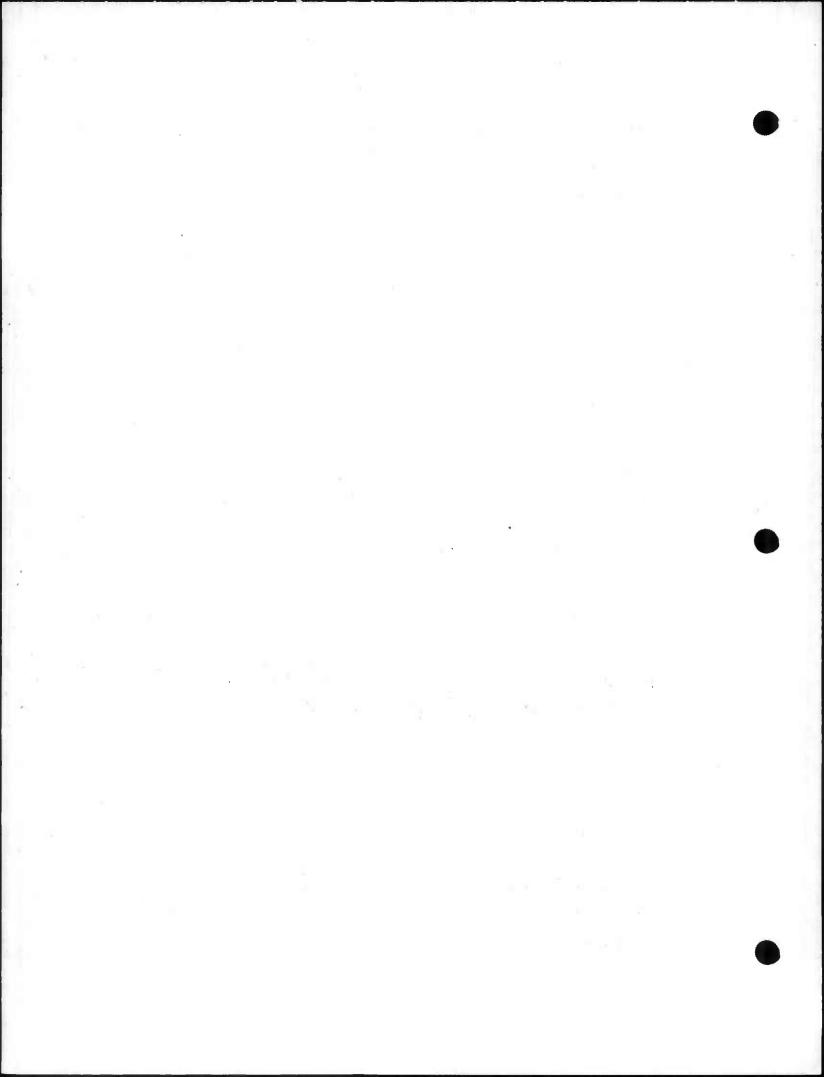
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jelson OS 11:58 am Jane 4. SOCIAL SECURITY NUMBER BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHE 1 🗌 M 2 ី F DAYS HOURS YRS. 220 36 9887 24 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Bon Securs Hospital Baltimore City NA RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland NA Baltimore City 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 916 Pennsylvania Avenue 21201 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Ri 1 YES 2 XNO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cook NA Restaurant 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) 75 Henry Little Louella Thomas BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Sherana Boston 916 Pennsylvania Ave. Balto, MD21201 pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Mt. Zion Cemetery 4 ☐ Donation 6 ☐ Other (Specify) 5/25/95 Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Unity Funeral 8. Home 108 W. North Avenue Balto, 21201 MD the medical 23. PART i. Enter the discess, or complications that caused the decade ahock, or heart fellure. List only one cause on such line. that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, Approximata Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) polo event, DUE TO (OR AS A CONSEQUENCE OF): or other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST item 23 shows any injury, PART II. Other aignificant/conditions contributing to death but not resulting in the inderlying cause 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? MEDICAL YES 2 PHO OF DEATH? sterence R2 01 en 1 YES 2 NO TOBACCO USE CONTRIBUTE CAUSE OF DEATH PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Ch **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 1 40 1 In Inpatient 2 ER/Outpatient 3 DOA me 5 Residence 6 Other (Specify) 0 TO THE HOSPITAL DR ATTENDING PHYSICIA TO THE FUNERAL DIRECTOR: After this certi be filed within 72 hours after death with the IMPORTANT: If item 28 is marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide datermined 1 DEATIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner se stated. 296. SIGNATURE AND TATLE OF CER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mpnth, Day, Year) 9

COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)



		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
		DECEDENT'S NAME (First, Middle, Last) SEPT SOCIAL SECURITY NUMBER	JOSEPH BERNAR	RD O'DONNELL	NNELL		2. DATE OF DEATH MONTH D	1995	уеая 3. Тіме оғ реатн 10:05 рт м					
pinc		213-05-2343 90. FACILITY NAME (If not institution, give	1 X M 2 □ F 80	6 YRS.		DAYS HOURS MIN.	July 1, 19	908	s. BIRTHPLACE (State or Foreign Country) Maryland					
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mit. Pages	DIRE		ford		ry, town on			1						
an. transit peri	FUNERAL	826 Comer Square				101. ZIP CODE 21014	EN OF WHAT COUNTRY?							
21215-0020 al or attending physician. for use as the burial-transit permit. Pages	BY	11. MARITAL STATUS 1 X Never Macried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 1 YES IF YES, GIVE WAR OR	S 2 XNO	II ye	S DECENDENT OF HISPA es, specify Cuben, Mexico YES 2 X NO Specif		s or No-	14. RACE — American Indian, Black, White, stc. Specify: White					
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	COMPLET	N/A	N/A	Offic	e Clei	100		Compa	ny					
YLA by the be de	TO BE CC	17. FATHER'S NAME (First, Middle, Last) Bernard O'Donnell	1			Anna V	AME (First, Middle, Malden	Sumame)						
MARYLAND retained by the hospit 5 should be detached notified at once.		19e. INFORMANT'S NAME (Type/Print)				treet end Number or Rural	Route Number, City or Tow	m, State, Zip C	Code)					
40		William B. Clayto			_	Square, Be		2101						
6 ma ctor. p		20a METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Ren 4 Donailon 5 Other (Specify)	noval from State	ob. PLACE AND DATE (emetery, cramatory or or fost Holy	of disposition ther place) Redee	Mer Cem			re, Maryland					
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7		AVVERAHALLI M. H.				TREAM RD.	BALTIMORE,	MD 212	236					
		MAY 23 1995	39. REGISTRAR'S SIGN	NAPURE										

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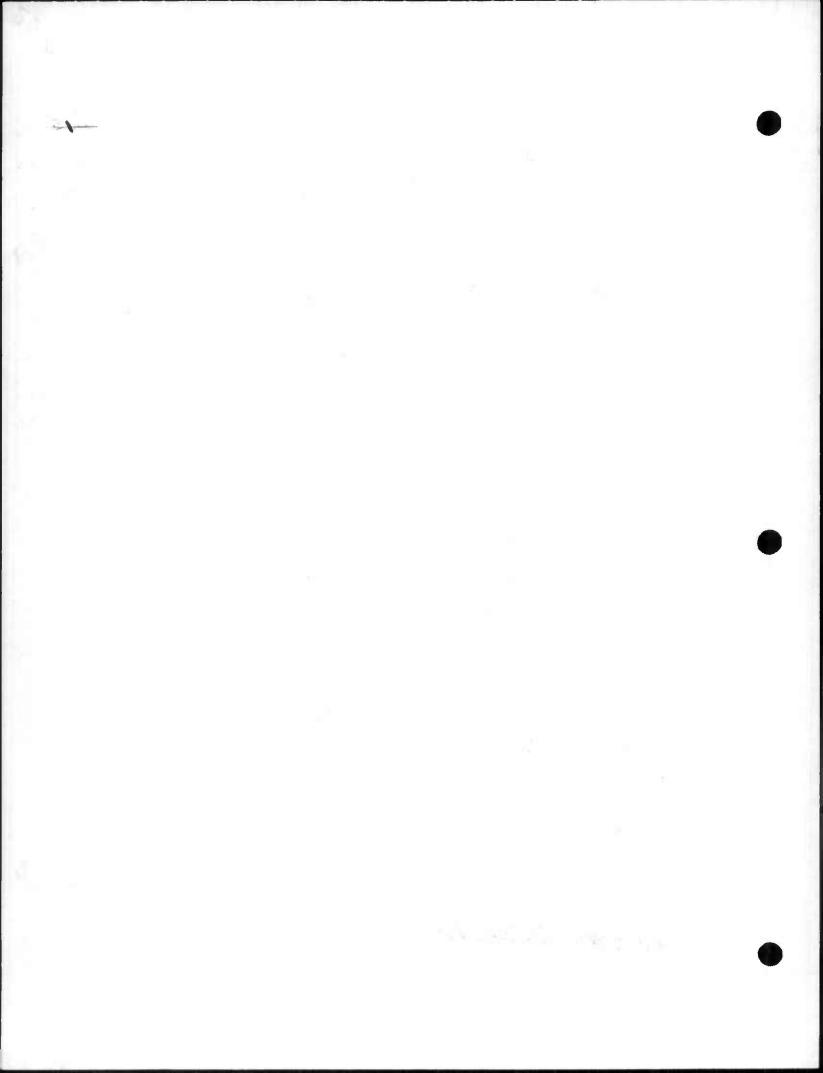
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29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 1305 Fitsen In. Beltenile Md 20705 31. DATE FILED (Month, Day, Year) 13. DATE FILED (Month, Day, Year)		AP	CERTIFYING PHYSICIAN: To the best of my knowle												
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31. DATE FILED (Month, Day, Year) / A 32. BEGISTRAN'S SONATUREA	15	[]	11305 Pitseen Dr. Belts	ville Md 2070	5										
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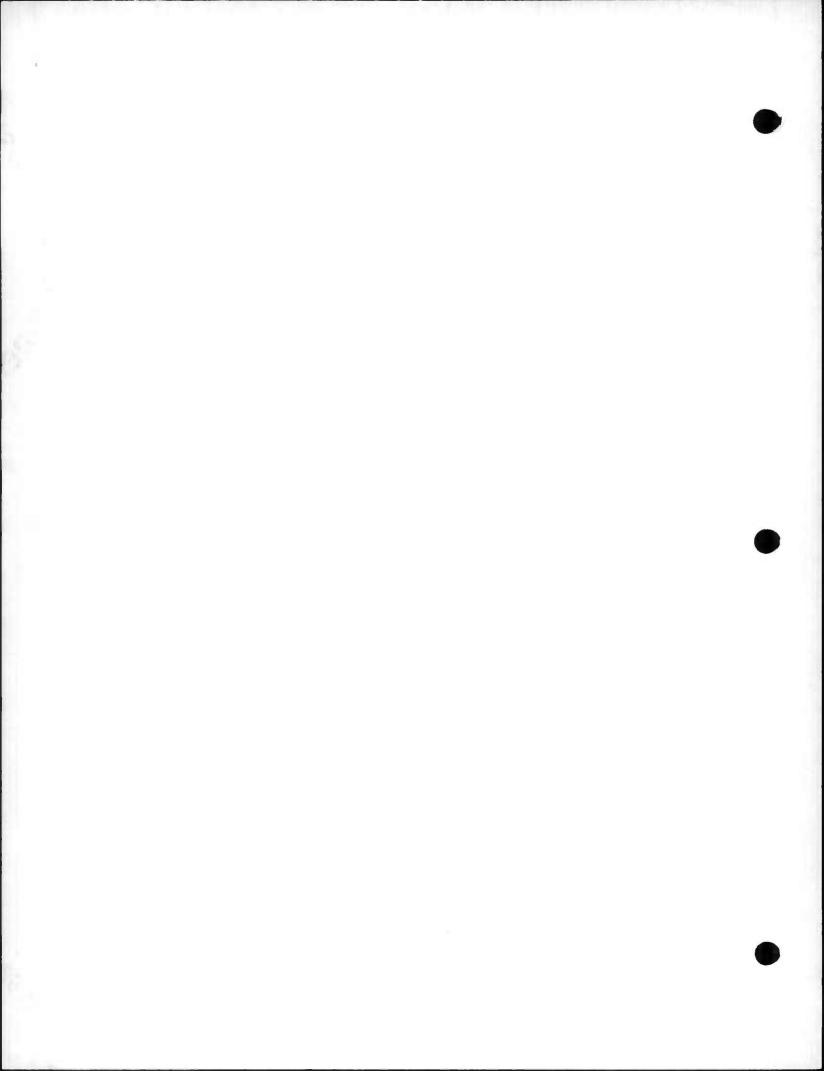


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		CELLIN COATE OF DEATH									
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH AV DAY DAY DAY DAY DAY DAY DAY DAY DAY DAY									
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. T. DATE OF BIRTH (Month, Day, Near) Soundry) S									
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1215-0 r attending use as the	G	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working									
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YLA be de de	ш	17. FATHER'S NAME (First, Middle, Last) Chester Portee 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Agnes Hawkins									
be retained ge 5 should e notified		ASOLEP J. Porter 5325 Wesley Ave, Balto, Md. 21207									
e 6 may rector, pa		20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemeter), demanding opening of pather place) 20c. METHOD OF DISPOSITION (Name of cemeter), demanding opening opening opening of the place of cemeter), demanding opening o									
death. P tuneral		21. SIGNATURE OF FUNERAL SERVICE ACENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS Funeral Home 22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS Funeral Home 22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS Funeral Home									
Z4 hours af r filled in by tion, or remother		23. PART Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate interval Batween Onset and Death disease or condition resulting in death)									
© 3 5 5 8		DUE TO (OR AS A CONSEQUENCE OF):									
		Sequentially list conditions, b. Congressions of the conditions, and the conditions of the conditions									
or to be	ITA:	if any, leading to immediate cause. Enter UNDERLYING									
tificati		CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):									
D. E S - 0		resulting in death) LAST									
the death the attent of Mental Finium, o		PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS									
Z # 4 5 % >	EDICAL	PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE									
Sea Sea Sea Sea Sea Sea Sea Sea Sea Sea		0 F DEATH? 1 □ YES 2 V NO									
AL RE te law reque has been Dept. of te	2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
A f a a E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTHER:									
SICIAN: The certificate h the State	YSI	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
그 돌 돌 를	ву Рн	27. MANNEY OF DEATH 1 Neture: 5 Pending 2 Accident Investigation 28. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO									
TTENDI TTENDI TTOR: A after d	品	3 Suicide 4 Homicide 8 Could not be determined 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)									
	PLE	29e. CERTIFIER (Check only LERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.									
HOSPITAL FUNERAL Within 72	l S	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated.									
TO THE HOSPITAL TO THE FUNERAL De filed within 72	TO BE (296. SIGNATURE AND DESCRIPTION OF SIGNED (Month, Day, Year)									
10	F	THE NET OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TYPO, PHIN) HOSPITAL BALTIMORE THOSPITAL BALTIMORE									
		MAY 2 3 1995 Julia d'Austrant Signature									

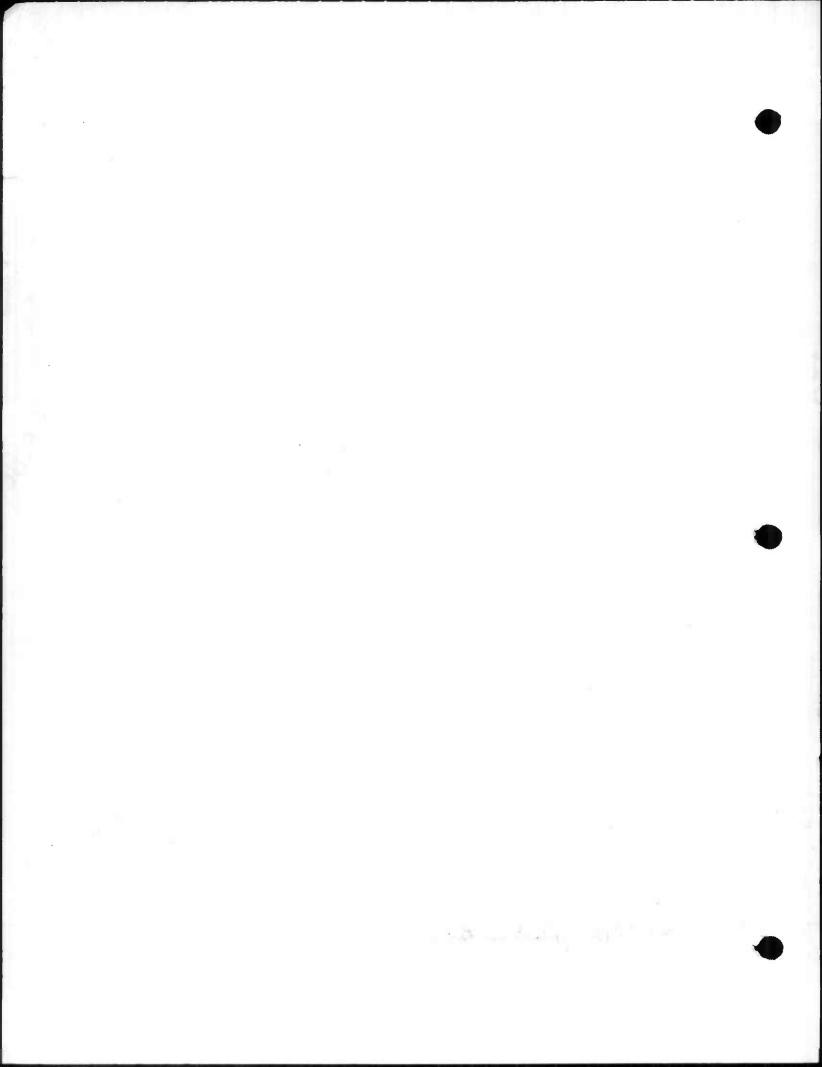
,		1 - STATE REGISTRAR	STATE OF M	ARYLAN	D / DEPAR					NTAL HYGIEN REG. NO				
	2000	1. DECEDENT'S NAME (First, Middle, Last) Watter PV	ilson						2.	DATE OF DEATH	· 194		TIME OF DEATH 9:42 PM	
		4. SOCIAL SECURITY NUMBER		6. AGE (In y	rs. lest birthday)	IF UNDER	1 YEAR	IF UNDER 2		DATE OF BIRTH (Month, Day, Year)			NCE (State or Foreign	
Pla		220-05-4148	1 M 2 D F		78 YRS.			HOURS	Ma	ay 15,		Sout	h Carolina	
3 should	œ	9a. FACILITY NAME (If not institution, give s							N OF DEATH		9c. COUNTY			
1, 2,	DIRECTOR	Liberty Medical C	1	<u>Ba1.t</u>	imore	5			n/a					
	IRE(10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN O	R LOCAT	ION			10d. INSIDE CITY LIMITS?					
permit. Pages		Maryland n/	Ba	1.timo	_	70.000			TYES 2 NO					
	FRAL	1011 Pennsylvania	201		100	ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?					
020 physician. burial-transit	FUNER	11. MARITAL STATUS	S. ARMED	13. V	MAS DEC	21201 ENDENT OF	F HISPANIC C	ORIGIN? (Specify Ye	Yes or No. 14. RACE — American Indian,					
-002 ing phy the buri	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA						Specify:	uerto Rican, etc.)	tc.) Block, White, etc. Specify:			
215-0 attending se as the	ED B	15. DECEDENT'S EDU	CATION	10.	a. DECEDENT'S	LIGHAL OC	CHEATIO	101			Black			
F 5 2	ETE	(Specify only highest grade Elementary/Secondary (0-12)	(Give kind of life. Do NOT u	work done a	luring mos	st of working	7	16b. KIND OF BU	SINESS/INDUS	TRY				
AND 2 he hospital detached for	COMPL	6th Grade	College (1-4 or 5+)		Sel.	f em	oloy	ed		Bark	er			
the hor detach	00	17. FATHER'S NAME (First, Middle, Last)	-						ER'S NAME (First, Middle, Maiden	Sumame)			
MARYLAND retained by the hospit 5 should be detached notified at once.	BE	Eugene Philson 19a. INFORMANT'S NAME (Type/Print)								Ziola Gi				
	2	Cathy Copeland			The second second					Number, City or Tox				
ALTIMORE, Jeath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION		20b. PL	3912						ore. N			
AOR pe 6 ma rector, p		1 Donation 5 □ Other (Specify)	oval from State		outus M	emori	la1	Park	1	19 Ra	ltimor	e Coi	intic MD	
death. Page tuneral dire		21. SIGNATURE OF FUNERAL SERVICE LA	SENSEE 1/	,		22. 1	NAME AN	D ADDRES	S OF FACILIT	Mutter	Funora	1. Ho	mes, Inc	
. 0 = 0		2501 Gwynns Falls Parkway Baltimore, Maryland 21216												
in by		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between												
d within 24 ho ompletely filled I, cremation, or event, the m		IMMEDIATE CAUSE (Final disease or condition resulting in death) End Stage Cordiomy & pathy DUE TO (OR AS A CONSEQUENCE OF): Acute Renal Fail we										Onset and Daeth		
P 2 2 2 2			DUE TO (OR AS A CO	NSEQUENCE O	n:	1/0							
P.O. BOX 6876 n certificate be executed ending physician and corr litygiene prior to burlat, or other traumatic en	RTIFICATION	DITE TO (OR AS A CONSCIUENCE OF).												
BO) ate be prior prior r trau	CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury												
certificate ding physical profiles or other t	E	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
DS, P.O. the death certif the attending the attending the mtal Hygier injury, or oth	CER	Tooling in dollar, Exist	d											
	CAL	PART II. Other significent condition	s contributing to	deeth but r	not resulting	in the un	derlying	ceuse gl	iven in Pari	t I. 24a. WAS AN			RE AUTOPSY FINDINGS	
OR So that and by aith and by	DIC									1 TYES	1/	CO	MPLETION OF CAUSE DEATH?	
w requires the been signed pt. of Health and shows a shows a show and shows a show and shows a show and shows a show and shows a show and shows a show a show a show and shows a show a s	MEDI											10	YES 2 NO	
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F 2 2 5	SICI	EXAMINER? 1 YES 2 YOUNG	HOSPITAL: 1 inpetient 2	ER/Outpatie	nt 3 DOA	OTHER	l:	s 5 □ Ree	Idence & 🗆	Other (Specify)				
PHYSICIAN: this certifical with the Str inked, or it	PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF II (Month, Day	NJURY	28b. TIM	T .	28c. INJL WOI	JRY AT		d. DESCRIBE HOW	INJURY OCCUP	NED		
ON OF ON OF After this of death with a marked,	BY	1 Natural 5 Pending 2 Accident Investigation	(moral), but	y, 10dir)		M		ES 2 [ND					
TTENDIN TTOR: At after de	8	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF building, e	INJURY — /	At home, farm,	street, facto	ery, office		281	LOCATION (Street City or Town, State)	and Number or	Rural Route	Number	
OIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma	1	29a CESTIFIES					_							
로로이트	COMPL	(Check only one) 1 CERTIFYING PHYSI One) 2 MEDICAL EXAMINE	CIAN: To the best of n											
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	111	29b. SIGNATURE AND TITLE OF CERTIFIER		arministra are	- Investigation	AI, III MY O	Jillion, de							
물 물 물 등	BE	Lomas CW	il III	MI).			D 4	1 13 G		P Ma		nth, Day, Year)	
223	2	30. NAME AND ADDRESS OF PERSON WH			(ITEM 27) (Type	Print)	, , ,	,	, ,	1 1 1			,	
5		George E. W	licks III	- M.	12	600	Lik	pert	y He	eights A	tre	212	.16	
		31 PATE THE (MONTH OF TOWN)	P RECISTRAR	SIG AVI	RE									



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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_		1. DECEDENT'S NAME (First,	Middle, Last)			OLITIII	IOAII		DLAI	-	_	HEG. NO.			
				AYNE							2. DATE OF MONTH MAY	19 th		YEAR 3	1128 A M
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	1		ACE (State or Foreign
-		216 05 4939		1 M 2 D F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	03 2	6 07		Virgi	
permit. Pages 1, 2, 3 should		90. FACILITY NAME (If not in:	stitution, give s	treet and number)			9b. CITY	TOWN	OR LOCATIO	ON OF DE	EATH			ITY OF DEA	
	CTOR	Saint Agnes	Hospi	tal			Ba1	time	ore			_	Balt	o. Ci	ty
	Ш	RESIDENCE OF DEC	10b. COUNT	Y		10c CI	TY, TOWN (DR LOCA	TION						Od. INSIDE CITY
	PIG	MD	Ва	ltimore		altim						LIMITS? 1 EXES 2 NO			
	FUNERAL	10e. STREET AND NUMBER						10	f. ZIP CODE				10g. CITIZ		AT COUNTRY?
ransi	N N	3236 Lohrs L	ane	12. WAS DECEDEN		21229						U.S.A			Α.
215-0020 attending physician. ise as the burial-transit	BY FU	1 Never Merried 2 Divo	NO						ORIGIN? (Specify Yes or No— Puerto Ricen, etc.) 14. RACE — / Black, W? Specify:			- American Indian, White, etc.			
215-0 attending se as the		41						opeany.	Black						
r afte	ETED		EDENT'S EDU- highest grade		16a.	(Give kind of	work done	CCUPATION	ON ost of workin		16b. Ki	IND OF BUS	HNESS/INDI	JSTRY	
ottal or d for u	7	Elementary/Secondary (0- 1.2	-12)	College (1-4 or 5 +		ille. Do NOT u		1				77 1			
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Mi	iciclio (net)	U		Self I	rmbro	yea				Unkn			
YLA by the be det	EC	William Wes					18. MOTHER'S N			Johns		Sumeme)			
MAR retained to 5 should	98	190. INFORMANT'S NAME (7)				ADDRESS	/Stroat					Chata 7/-	0-4-1		
2 2 0 2		Mary Carrol		19b. MAILING ADDRESS (Street end Number or Rural Route 714 Whitmore Ave. Balto							Lode)				
MORE, age 6 may be director, page		200. METHOD OF DISPOSITE	ON	LACT DE	CE AND DATE						_	LOCATION — City or Town, State			
		1 Donation 5 □ Other		oval from State	Arbuti	rematory or other place) Trbutus Mem. Park 5/			5/25	/95		butus, Maryland			
		21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	10	0			22. NAME AND ADDRESS OF FACILITY					-	
ALLI death. P. death. P. funeral	1	Estep Bros. Funeral Home P.A.													
Ours after of in by the or removal.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximeta													
_ 0 0 0 E		Interval Between													
		disesse or condition Mart 1													
ted within, completely ial, cremati		resulting in death)		DUE TO	OR AS A CON	SEQUENCE O	ena F):	w	lan	RIM	ma				2 years.
executed v and comp to burial, c		2													1
e be execute sician and c rior to buris traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
ficate be ophysician ne prior to	2	CAUSE (Disease or injur		C. DUE TO	OR AS A CON	DECULENCE O	-								
eath certifica attending phy mal Hygiene	Ē	that initiated events resulting in death) LAST	r	DOE 10	(OR AS A CON	SECUENCE O	rF}:								
earthe arte	B			d											1
	¥.	PART ii. Other significer	nt condition	s contributing to	desth but no	t resulting	In the un	deriyin	g ceuse g	lven in	Part i. 24	HI. WAS AN			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
uires that signed by Health an											1	YES 2		CC	OMPLETION OF CAUSE
requires been sign of Heal	-										_			1	TES 2 NO
	AN			RIBUTE TO CAI	CAUSE OF DEATH YES NO UNCERTAIN					1 🗵					
- F 2 2 5	SICI,	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:		ACE OF DEA	TH (Check)								
SICIAN: The certificate in the State		1 YES NO		1 D Inpetient 2 D			4 🗆 Nun	Ing Hom		sidence	S C Other (S				
子語音	0	Netural 5 F	Pending	(Month, De		28b. TIN	JURY	-	RK7		28d. DESCR	HBE HOW IN	JURY OCCI	JRED	
After death		3 Suleido	nvestigation	28e. PLACE OF	FINJURY — AI	home, ferm.			YES 2	NO	28f. LOCATIO	DM (Street or	nd Mumbas a	Description of	4
S after 5	臣		Could not be letermined	building, o	etc. (Specify)			,,,	•		City or T	own, State)	id Number d	Y HUNEI HOUR	i Number,
BI DIR	1	29e. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of I	my knowledge.	death occurr	ed at the ti	me date	and place	and due	to the course	a) and man		-	
HOSPITAL FUNERAL within 72 h				R: On the beele of ex											nd manner ee stated.
THE HOSP! THE FUNEF filed within	Ö	296 SIGNATURE AND TITLE							29c. LICEI						onth, Day, Year)
THE OF THE DE SILED		Germa-	NI	Spend D.	of m	D			02	240	54		▶m	De a d	8 100-
11	5	30. ME AND ADDRESS OF	PERSON WHO	COMPLYTEO CAUS	E OF DEATH (I	TEM 27) (Type	, Print)		000	776			1/2	d	7,7975
4		VJEROME.	I. SA	VOER n	1 . D.	900	5.0	ATT	A) AI	IE.	BA	Tim	nDE	ma	21229
-		31. DATE FILEO (MONTH, Day, W	bar)	32. REGISTRAF	R'S SIGNATURE			,0	, () 7)		0,72	-1 17770	,,,,,		21221
		100 mm	is you	AN SURVINGE	hardall										



			1 - STATE REGISTRAR	STATE OF MARYL	AND / D	EPARTME	NT OF H	EALTH AND DEATH	MENTAL	HYGIENE REG. NO.			
			1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH			TIME OF DEATH
				ranklin Par	lett				Мау	17 1	.995	AR	1:20am
			4. SOCIAL SECURITY NUMBER	A THE RESERVE OF THE PERSON OF	(In yrs. last bi	BECONTY	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH Day, Year)	0.1	HRTNPL	ACE (State or Foreign
	9		213–10–4357	1 😾 M 2 □ F	88	YRS.				7, 190)6	Maı	cyland
	3 should	α	9a. FACILITY NAME (If not institution, give			96. 0		R LOCATION OF O	EATN	1	9c. COUNTY		
	1, 2,	СТОВ	Meridan-Cromell	Nursing Cent	re		To	wson			Ba1t	imoi	ce
	Pages	H	10a, STATE 10b. COUN			IOc. CITY, TOW	N OR LOCAT					10	d. INSIDE CITY
	nit. P	ō		Baltimore				Parkv	/ille			1	YES 2 1 NO
	t permit.	RAL	10e, STREET AND NUMBER				101.	ZIP CODE		1	10g. CITIZEN	OF WHA	T COUNTRY?
ian.	burial-transit	NER	3519 Northway I					21234				J	JSA
)20 ohysic	Durial	FUN	1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 NO	D	If yes, spe	ENDENT OF NISPAI ocify Cuban, Mexico	en, Puerto Ric			Black, W	American Indian, hite, etc.
215-0020 attending physician.	ê	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	AIES		1 YES	2 K NO Specif	fy:			Specify:	White
21215-0020 of or attending physic	use as	9	15. OECEDENT'S ED (Specify only highest grad	UCATION fe completed)	16a. DECE	DENT'S USUAL	OCCUPATIO	IN et al wadding	16b. K	IND OF BUSIN	ESS/INDUST		
		LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIa. Do	NOI use retire	d.)	a or working					
LAND 2 the hospital	detached once.	COMPL	8th 17. FATHER'S NAME (First, Middle, Last)		T	ruck D	river				a Yea	st	
YLA by the	at de		Benjamin F.	Parlott			Ì	18. MOTNER'S NA		Idle, Maiden Sur Turri			
MARYLAND retained by the hospit		8	19a. INFORMANT'S NAME (Type/Print)	Tarrect	19h 8i	IAH ING ADDR	ESS /Street or	nd Number or Rural					
N e reta	2 2	2	Michael Camp	bell				Drive E					
ÄË,	page it be		20a. METHOD OF DISPOSITION	200		DATE OF DISE			DATE		TION — City		State
0 50	must		1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ret 4 ☐ Donation 5 ☐ Other (Specify)		etery, cremate ceneze	ory or other place Cem	eterv	5/19	9/95	1	timor		
F Pag	e funeral dir J. examiner		21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	11		2. NAME AN	D ADDRESS OF FA	CILITY				
BALTIMORE, after death. Page 6 may be			1. Terre	1 (00)	10,			lly Fune					
T afte	d in by the or removal medical		23. PART I. Enter the diseases, or	complications that ceused	the death	Do not en	ter the mod	de of dying, suc	h se cardia	c Dr respirat	lory arrest,	1221	Approximate
4 hours			IMMEDIATE CAUSE (Final	A 1	och ling.					,			Onset and Dea
60 within 24	cremation,	l	disease or condition resulting in deeth)	. ARKERIO	clen	etie (OVOM	aryart	teryo	lesea	Le		
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C 687	and o bur	CERTIFICATION	Sequentially list conditions,	b. OUE TO (OR AS A	-		Lear	<u> </u>					
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O. B.	other other	Ĕ	CAUSE (Diseese or injury thet initiated events	OUE TO (OR AS A	CONSEDUE	NCE OF):							
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RDS, at the dea	를 물을	AL C	PART II. Other significant condition	ns contributing to death b	ut not resu	liting in the	underlying	ceuse given in	Part I. 2	4s. WAS AN AU	meev	245 WE	RE AUTOPSY FINDING
œ =	200	ŏ	<u>A</u>						1	PERFORME	0?	ANA	ILABLE PRIOR TO MPLETION OF CAUSE
RECOR	been signed to the both a shows any	MEDIC	Cer	elvova culs	va	cul	ant		_ 1	☐ YES 2 M	NO	OF	DEATH?
	The sec	ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH	YES [NO Z	- UNCERTAIN	NO			1	YES 2 NO
TAL The law	State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			F DEATH (Che	ck only one)						
ZAN.	he Sta	YSI	1 TES 2 TONO	1 Inpatient 2 ER/Outp	atlant 3 🗆	DOA 4 AC		5 Residence	6 Other (S	Specify)			
OF PHYSIC	his ce with t	표	27. MANNER OF DEATN 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	21	Bb. TIME OF INJURY	28c. INJU WOF	RK?	28d. DESCR	NBE HOW INJU	JRY OCCURE	D	
NG P		B	2 Accident Investigation	280 BLACE OF IN HUDY	At ham	M		ES 2 NO					
OR ATTENDING PHYSICIAN:			3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	At nome,	ferm, street, I	actory, office		26f. LOCATI City or	ON (Street and Town, State)	Number or Ru	irel Route	Number,
OR AI	DIRECTOR: hours after item 28 la	COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS										
	로인도	MP		ER: On the best of my knowledge.									
HOSPITAL	TO THE FUNERAL De filed within 72 IMPORTANT: If	- 11	29b. SIGNATURE AND TITLE OF CERTIFIE				y opinion, de						
TO THE	TO THE be filed	B	Marin Kerry	luce m	'>			29c. LICENSE NUM	U ZZ				nth, Day, Year)
2	F 2 &	2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DE	ATH (ITEM 27	(Type, Print)					5-	//	73
(y		MARIAN KINEA	LEUSKI 8	6041	HARP	UKS	nd 1	Ain	.us	2117	3 Y	
1)		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE	. ,	/	()	100				
		1	MAY 2 3 1995	hi Mudeor Rand	all								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH A -44 Phillips Mary

4. SOCIAL SECURITY NUMBER 1995 May 0325 5. SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH e. BIRTHPLACE (State or Foreign Country) Haryland IF UNDER 1 YEAR IF UNDER 24 HRS. 214-44-4387 Oct. 2,1945 HOURS 1 M 2 M F 49 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Honkins at Rayview Baltimore 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 3800 Hudson Street funeral director, page 5 should be detached for use as the burial-transit 21224 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION early only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY (Spi Elementary/Secondary (0-12) College (1-4 or 5+) Mfg. 10 Personnel Sup. once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Arthur Tellis Ħ Louise Sobus BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Angeline Wagner 5343 Hollowstone Circle, Balto. Md. 21237 cuted within 24 hours after death. Page 6 may be 1 completely filled in by the funeral director, page 5 rial, cremation, or removal. must be 20e, METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE St. Stanislaus Cemetery 5/24 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY A. Weber & Sons Inc. Ann St. Balto. Md. 21231 ge S. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heert failure. List only ona cause on sech line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition CARDIAC ARRHYTHMIA resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wit an and com MYOCARDIAL FIBROSIS CERTIFICATION Sequantisity list conditions, OUE TO (OR AS A CONSEQUENCE OF): attending physician a ental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initisted events DIVISION OF VITAL RECORDS, P.O. resulting in death) LAST 20 Health and Mental H Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 YES 2 - NO 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate h EXAMINER? HOSPITAL:
1 | inpetient 2 | ER/Outpatient 3 | DOA OTHER: 4 Nursing Home 5 Realdence 6 Other (Specify) 0 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED this c marked. 1 X Netural 5 Pending BY 1 YES 2 NO After death 2 Accident DIRECTOR: Att hours after deal item 28 is n 28e. PLACE OF INJURY — At home, tarm, strast, tactory, offica building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If Item 2 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) and manner ea stated. ATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) O.C.M.E. May 21 1995 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

BALTIMORE, MARYLAND 21215-0020

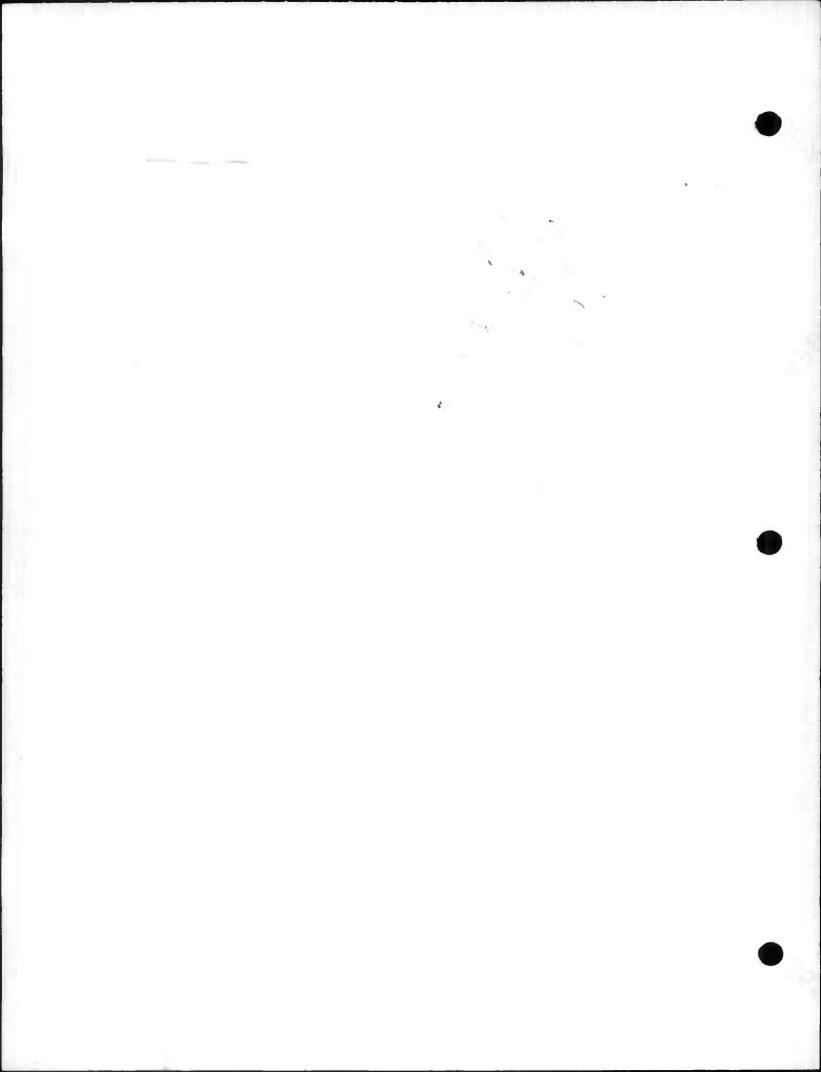
DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO BE COMPLETED BY FINERAL DIRECTOR	
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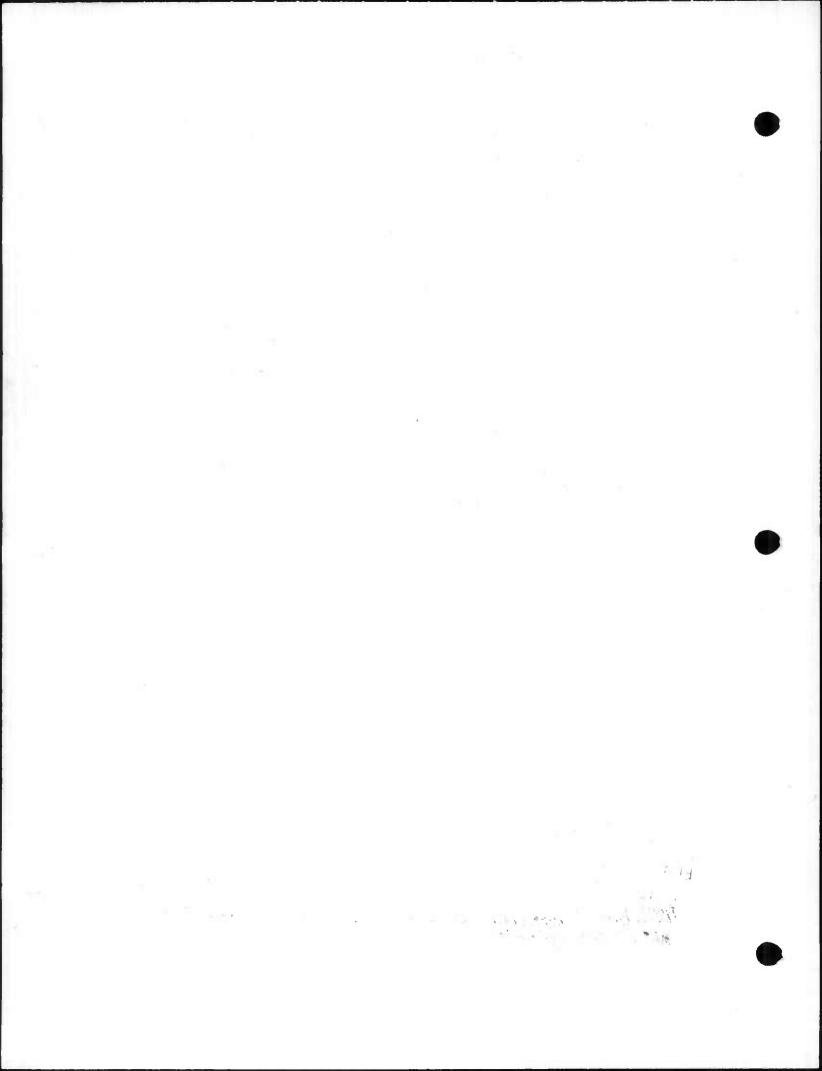
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, La	ist)							2. DATE	OF DEATH			3. TIME OF DEATH
	TYRONE			POWE	LL				MAY	12, 1	995	YEAR	3:55 A _M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	l birthday)	IF UNDER		IF UNDER		7. DATE	DF BIRTH		B. BIRTI	HPLACE (State or Foreign
	224-88-2905	1 🔀 M 2 🗌 F	37	YRS.	MONTHS	DAYS	HOURS	MIN.	-May	4,1958 12	1995	Count	79)
~	Sa. FACILITY NAME (If not institution, ga					, TOWN O			ATH		9c. COU	TY OF E	DEATH
OT.	THE JOHNS HOP		TAL		BA	LTIM	ORE	CITY					
DIRECTOR	10a. STATE 10b. COL			10c. CIT	Y, TOWN I	OR LOCATI	ION						10d, INSIDE CITY
	Maryland			Ва	ltim	ore							LIMITS? YES 2 ND
IAL	10e. STREET AND NUMBER					101.	ZIP CODE				10g. CITI	ZEN OF	WHAT COUNTRY?
FUNERAL	1726 N. Gay St						212	13					
F	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. ARI		13.	WAS DECE	ENDENT O	F HISPAN	IIC ORIGIN	7 (Specify Yes	or No-	14. RAC	E — American Indian, k, Whita, stc.
84	3 Widowed 4 Divorced	IF YES, GIVE W	WAR DR DATES			1 YES				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Spec	
ETED	15. DECEDENT'S	EDUCATION	16a, DE	CEDENT'S	USUAL O	CCUPATIO	N		16h	KIND OF BUS	SINESS/IND	LISTRY	DIACK
(Specify only highesi grade completed) (Give kind of work done during the completed) (Give kind of work done during the completed) (Give kind of work done during the completed)						during mos	al of working	g			JII COO 1110	001111	
M													
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, A	liddle, Maiden	Sumame)		
BE										_			
2	19a. INFORMANT'S NAME (Type/Print)		191:	. MAILING	ADDRES	S (Street an	nd Number	or Rural F	Poute Numb	er, City or Tow	n, State, Zip	Code)	
	20s. METHOD OF DISPOSITION							-	_				
	1 Buriel 2 Cremation 3 R	emovel from State	20b. PLACE A cemetery, cres	matory or o	ther place)	SITION (Nan	ne of		DATE	20c. LO	CATION —	City or To	own, State
21. SIGNATURE OF EMERAL SERVICE UCENSEE ROnald Wade, Dir, 22. NAME AND ADDRESS OF FACILITY State Anaton							ny B	oard					
655 W. Baltimore St., Balto., 1													
-/	23. PART I. Enter the diseases,	or complications the	t caused the dea	ath. Do r	not enter	the mod	ie of dul	na such	on cord	les or mani	ratan, am	- ort	I Assessification
- 1	shock, or heart failu IMMEDIATE CAUSE (Finel	. List only one ceu	ise on each line.										Approximate interval Batween Onset and Death
	disease or condition resulting in death)	cerebra											
	DUE TO (DR AS A CONSEDUENCE OF): Multi-5 nb 8 tange abuse Multi-5 nb 8 tange abuse												
Z	Sequentially list conditions,	multi-	- 5 nb8+	diria	e A	bus	e						2 i den makenon
ATIO	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE. Chief there is the cause of the										the state of		
길	CAUSE (Disease or injury that initiated events	c. DUE TO	OR AS A CONSED	UENCE O	F)·								monus
CERTIFICATION	resulting in deeth) LAST	=4	(JE110E 0	,								
	DART II Other desidence	_ 6.											
MEDICAL	PART II. Other algnificent condit	ione contributing to	deeth but not re	sulting	in the un	derlying	ceuse g	lven in	Part I.	24s. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă									-	1 TYES 2	NO		OF DEATH?
	DID TOBACCO USE COM	ITPIRITE TO CA	LISE OF DEAT	ru ve	сПі	ио П	LINIC	EDTAIN					1 TYES 2 ND
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			E DF DEAT			UNC	EKIAIP	I M				
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	₹:	5 □ Par	Idence	6 🗆 Other	/Sanaihi)			
ξ	27. MANNER OF DEATH	26e, DATE OF (Month, Di	INJURY	28b. TIM	E OF	28c. INJU	IRY AT		_	CRIBE HOW II	NJURY OCC	URED	
ВУ	1 Netural 5 Pending 2 Accident Investigation		ay, reer/	INJ	URY M	1 Y		NO					
	3 Suicide 6 Could not	bullding.	F INJURY — At hon atc. (Specify)	ne, larm, a	street, fact	ory, offica			281. LOCA	TIDN (Street a	nd Number	or Rural F	Route Number,
	4 Homicide determined												
AP	29e. CERTIFIER (Check only one)	YSICIAN: To the best of	my knowledge, des	th occurr	d at the t	lme, data a	and place,	and dua	to the cau	e(a) and man	mer as state	id.	4
COMPLETED	2 MEDICAL EXAM	INER: Dn the beals of ax	cemination end/or in	nvestigatio	n, In my o	pinion, de	ath occurs	d at the	lime, date	and place, and	d due to the	cause(a) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIF	/-	111	1	000		29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
2		ND PULL	1/1	4	1)		44	27		•	5/	12/95
	30. NAME AND ADDRESS OF PERSON Xue Ming	large 1		A 1750A		est	1/2	Bata	Timo	es 1	ND =	212	05
	31. DATE FILED (Month, Day, Year) 995 32. REGISTRAR'S SIGNATURE												



		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.								
		1. DECEDENT'S NAME (First, Middle, Last)	Queen	/			2. DATE OF DEATH			TIME OF DE	ATH O M
		4. SOCIAL SECURITY NUMBER 220 22 1362		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		ACE (State or i	Foreign
should s	·	9e. FACILITY NAME (If not institution, give str	reet end number)		9b. CITY, TOWN C	OR LOCATION OF DE	LIS I/	7 1	TY OF DEAT		
1. 2, 3	стоя	Sinai Hospita.	<u>L</u>		Ba.	ltimore	City		NA		
permit. Pages	DIRE	Maryland 10b. COUNTY	NA	10c. CITY,	TOWN OR LOCAT	Baltimo	re Citv			d. INSIDE CIT LIMITS? YES 2	
	ERAL	3604 Forest Par	ole Arranua		101	. ZIP CODE		10g. CITIZ		T COUNTRY?	
020 physician. burlal-transit	FUNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U FORCES? 1 YES	U.S. ARMED	13. WAS DEC	212 ENDENT OF HISPAN	IIC ORIGIN? (Specify	Yes or No.— 1	USA 4. RACE -	American Inc	llen,
215-0020 attending physician, se as the burial-trar	B≺	1 Never Married 2 Merried 3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DATI			2 MO Specify	n, Puerto Rican, etc.)		Specify:	hite, atc. Blac	1,
	ETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION 1	Give kind of wo	rk done durina ma	ON st of working	16b, KIND OF	BUSINESS/INDU	STRY	Diac	K
ND 2. hospital o ached for	APLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	netirod.) Dusewii	Fo	н	omemak			
A se se	COMPL	17. FATHER'S NAME (First, Middle, Last)			USEWI		ME (First, Middle, Mei		er		
MARYL retained by 5 should be notified at	B	James Nicho. 190. INFORMANT'S NAME (Type/Print)	ls	19h, MAILING A	DORESS (Street e	Lotti	Oute Number, City or	From Comin 7in (N- al- (
5 5 5 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5 6 5	2	Racheal Nichols	on				Ave. Ba			216	
6 may stor, pa		20e. METHOD OF DISPOSITION M Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State 20b. P	ACE AND DATE OF	DISPOSITION (No	me of	DATE 200	LOCATION OF	A T	Otes	
		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	ula kla	22. NAME AN	ID ADDRESS OF FAC			lle.	MD	
		Dr. E. 46	well, In		Unit	y Funer	ral Home th Aveni	e Ral	+ 0	MD 2	1 2 0 1
urs aft In by r remo		23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused to	he death. Do no	t enter the mo	de of dying, such	as cerdiac or re	epiratory arre	et,	Approxin	nata
# S S S		iMMEDIATE CAUSE (Finei disease or condition	Phelir	moni	a					Onset an	
B 6 8		resulting in death)	DUE TO (OR AS A C	CONSEQUENCE OF):						~ ~ ~ ~	
and burn	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):							
ficate be physician to prior trau	ERTIFICATION	CAUSE (Disease or injury	DUE TO (OR AS A C	CHARALIENAE AD							
h certification of other	HTH	that initiated events resulting in death) LAST	DOE TO (OH AS A CI	ONSEQUENCE OF):							
HUS, P.O. Bot at the death certificate by the attending physisand Mental Hygiene principlary, or other the	O	PART il. Other significent conditions	contributing to death but	not resulting in	the underlying	ceuse given in	Part I. 24s. WAS	AN AUTOPSY	24b. WE	RE AUTOPSY F	INDINGS
and the the the the the the the the the the	MEDICAL						PERF	ORMED?	CO	ILABLE PRIOR MPLETION OF DEATH?	10
2 5 5 4		DID TOBACCO USE CONTR	IRLITE TO CALISE OF	DEATH VEC		LINICEDTAIN	7			YES 2	NO
N: The law cate has be State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH		UNCERTAIN	1 🛛				
SICIAN: The certificate the State , or item	HYSIC		HOSPITAL:	ent 3 DOA 4		5 🗆 Residence					
ING PHYS free this ceath with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME (TY WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE HO	W INJURY OCCU	RED		
TTEND TOR: A after d	ETED B	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, stre	set, fectory, office		261. LOCATION (Stree City or Town, Sta	et end Number or ste)	Rural Route	Number,	
R DIR	APLE		IAN: To the best of my knowled								
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: IF I	COMPL	29 SIGNATURE OND TITLE OF CERTIFIER	On the basis of examination e	ind/or investigation,	In my opinion, de			end due to the	ceuse(e) en	d menner ee i	stated.
TO THE De filed IMPOR	BE	M. Mels	-DO			29c. LICENSE NUM	BER 21 RAG G 97	29d. DATE !	TILL I	Day, Year	95
<i>j</i>	5	30. MANIE AND ADDRESS OF PERSON WHO	AI W	SPIT	AI	00/10	7,11	4			
9		31. MAY 2 3 1995 Jul	A REGISTRAR PERMIT	Y.		11 / /		16-			

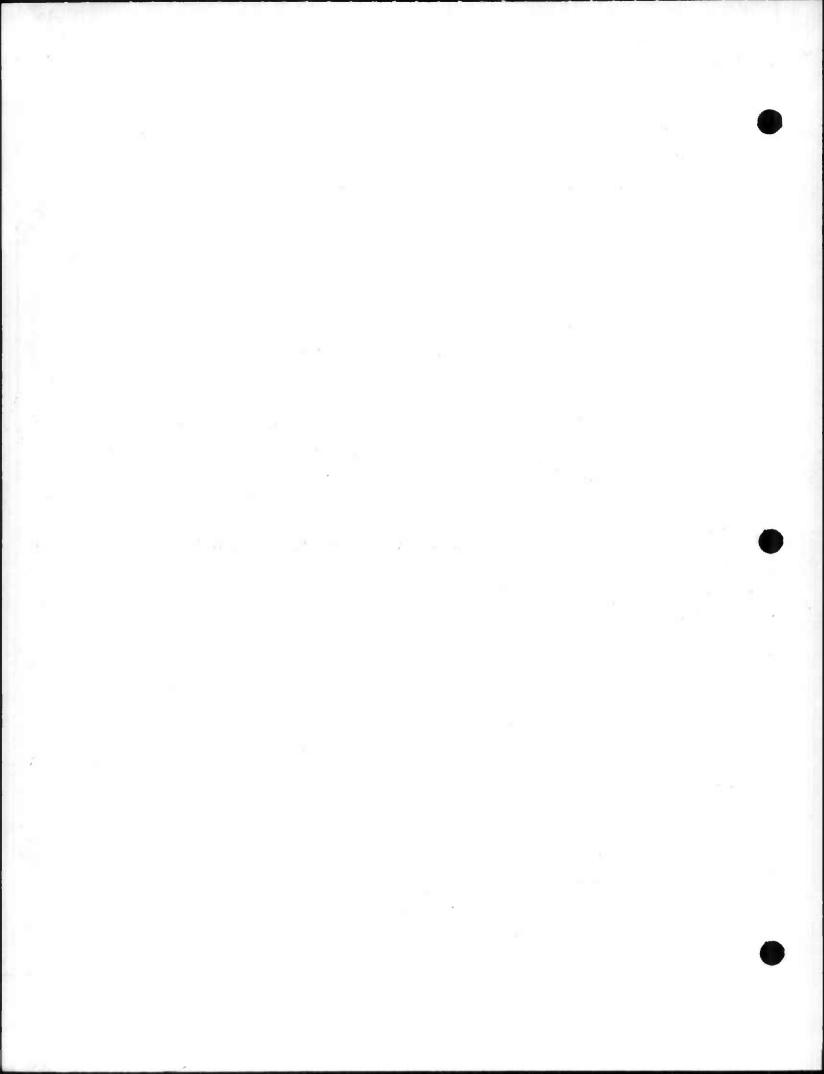


IE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 7.4 hours after death. Page 6 may be retained by the hospital or attending physician.	4F FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the hurial-transfr nermin Pages 1 2 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITA	TO THE FUNERA	oe filed within 7.	MPORTANT: I

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

-71	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH		
	ANNE E. RUDE				5 21	1995			
	01 - 10		IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH MORTH, Day, Year, MAR 6, 192	8. BIR	THPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give atreet and number)		9b. CITY. TOWN C	OR LOCATION OF DE		9c. COUNTY OF	yland		
OR	514 UMBRA STREET		BALTIM		ETY	N/A	DEATH		
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	10c. CITY.	TOWN OR LOCAT	ION			10d. INSIDE CITY		
	Maryland N/A		Baltimo				LIMITS?		
FUNERAL	10e. STREET AND NUMBER		101	. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
514 Umbra Street 21224 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGINAL SPACE AND 14. RACE AND 15. WAS DECEMBENT OF HISPANIC ORIGINAL SPACE AND 14. RACE AND 15. WAS DECEMBENT OF HISPANIC ORIGINAL SPACE AND 14. RACE AND 15. WAS DECEMBENT OF HISPANIC ORIGINAL SPACE AND 15. WAS DECEMBED AND 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15. WAS DECEMBED OR 15.									
FU	1 Never Married 2 Married FORCES? 1 XY	ES 2 NO	If yes, sp	cify Cuban, Mexica	IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	Bla	CE — American Indian, ick, White, etc.		
) BY	3 Wildowed 4 Divorced	DATES	1 1 123	2. NO Specify	<i>r</i> .	Sp	White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done during ma	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY			
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	Secretary		Typist	Office/T	ravel A	gency		
OM	17. FATHER'S NAME (First, Middle, Last)	,	,	J. L.	ME (First, Middle, Maiden		Geney		
BE	Anthony Andrew Rudell				ret Katheri				
0	19a. INFORMANT'S NAME (Type/Print) Charles P. Rudell				Route Number, City or Town				
	20e. METHOD OF DISPOSITION	20b.PLACE AND DATE OF			DATE 20c. LOC		Young Chat		
	1 Gentler 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metro crema	atory,	Inc. 05/2	22/95 Bal	timore,	MD		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AN	D ADDRESS OF FAC	lety of Mar	ryland	Inc		
	George E. MacNabb		299 F	rederick	Rd. Baltin	nore, MD	21228		
ATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	S A CONSEQUENCE OF):							
AL CE	PART II. Other significent conditions contributing to deet	but not resulting In	the underlying	ceuse given in i	Part I. 24e. WAS AN	MITTIPSV 24	b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICA					PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
. M	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	Пиог	UNCERTAIN			1 YES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH		011021(17(1)					
YSI	YES 2 NO 1 Inpatient 2 ER/O		OTHER: Nursing Home	5 X Wesidence	6 Other (Specify)				
ву Рн	27. MANNER OF DEATH Netural 5 Pending		WO WO	JRY AT RK? ES 2 NO	26d. DEŞCRIBE HOW IN	JURY OCCURED			
COMPLETED		IRY — At home, ferm, stripecify)	et, factory, office		281, LOCATION (Street at City or Town, State)	nd Number or Rura	Route Number,		
P	29a. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my kn	owledge, death occurred	at the time, data	and place, and due	to the cause(s) and mani	ner as stated,			
Sol	MEDICAL EXAMINER: On the beats of examina	tion end/or investigation,	In my opinion, de	ath occured at the	time, data and place, and	due to the cause	(a) and manner as stated.		
8	296. SIGNATURE AND TITLE OF CERTIFIER	MD		29c. LICENSE NUM		29d. DATE SIGNE	D (Month. Day, Year) 21 1995		
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF								
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SI	GNATURE	OIKEET.	BALTI	ORE, MD. 2	1201			
	MAY 2 3 1995 Julia drivalsanta	Nell							



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 flours after death, Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If New 28 le marked ne liem 22 chause any fatury de other traumatic examiles avanting avantant must be avaited at another
2		_	

	1 - STATE REGISTRAR	STATE OF MARYLAND / I	DEPARTMENT OF I	IEALTH AND I	WENTAL HYGIE		
	1. OECEDENT'S NAME (First, Middle, Last)	70.	01.1		2. DATE OF DEATH MONTH	DAY YEAR	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER	ERNEST	RIC	4	MAY	7 1995	130 P M
	NID TO 0.10	5. SEX 6. AGE (In yrs. last t	VRS. IF UNDER 1 YEAR MONTHS BAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give stre	70		OR LOCATION OF DE	11 25	48 N	gry gwa
DIRECTOR	Western MarylF RESIDENCE OF DECEDENT!	and Health Cen	to Hao		on_	9c. COUNTY OF	1
R	10e. STATE 10b. COUNTY	^	10c CITY, TOWN OR LOCA	TION			10d. INSIDE CITY
	Mananci N/	A	13al tim	one			1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER	C Laco	1	, ZIP CODE	n	10g. CITIZEN OF	WHAT COUNTRY?
1 8	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMI	ED 13 WE DE	<u>alal</u>		14.0),
	1 Never Married 2 Merried	FORCES? 1 YES 2 NO	If yes, sp	ecify Cuben, Mexican	IIC ORIGIN? (Specify Yon, Puerto Rican, etc.)	Bit	CE — American Indian, ick, White, etc.
BY	3 Wildowed 4 Divorced	ARMY 3-28-69	2-14-70	эрвену		Sp	Black
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted) (Give	EOENT'S USUAL OCCUPATED kind of work done during mo	DN ost of working	16b. KIND OF BI	SINESS/INDUSTRY	
님	Elementary/Secondary (0-12)	College (1-4 or 5+) Colle	Oo NOT use retired.)		0	201-11-	Linul
NO	17. FATHER'S NAME (First, Middle, Last)	130000	19borer	18. MOTHER'S NAI	ME (First, Middle, Maide	USTINC	TION
BE C	Ernest K	lich		Vilia	Crari	nett	
10	19a. INFORMANT'S NAME (Type/Print)	196.	MAILING ADDRESS (Street	and Number or Rural F	Poute Number, City or To	vn, State, Zip Code)	21217
=	Preston 191	ch 17	18 N.C	are 4 8	Street F	paltimon	e Marybrod
	20a, METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Remov	al from State 20b. PLACEAN	ID DATE OF DISPOSITION (Na	ame of	DATE 20c. L		Town, State
	4 Donation 5 Dilher (Specify)		CARRISON	torest	3-26 31	altim	one
	II. SIGNATURE OF THIRDAL SERVICE ELLE	isee On	TYV I	NO CAM		eral t	ome
	193	wee_	171	2 WIN	Vorth	AUCNL	re
	23. PART I. Enter the diseases, or co shock, or heert failure. Li	mpilcetions that ceused the deet st only one cause on each line.	th. Do not enter tha mo	de of dying, such	as cardiec or reap	piratory arrest,	Approximate interval Between
	iMMEDIATE CAUSE (Finsi disease or condition resulting in death)	EXCESSIVE I	PULMONA	RY MU	cous		Onset and Death
			•				UNKNOWN
NO N	Sequentially list conditiona, b.	PNEUMONIT					
SAT	if sny, leading to immediate cause. Enter UNDERLYING	RESTRICTIVE	LUNG	DISEAS	F		1972
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQU		,,,,,			1112
CERTIFICATION	resulting in death) LAST	QUADRIPLE	GIA				1972
AL C	PART II. Other significent conditions	contributing to death but not rar	suiting in the underlying	g ceuse given in i	Part i. 24a. WAS AI	AUTOPSY 2	Ib. WERE AUTOPSY FINDINGS
2	HISTORY OF: 1)	DECUBITUS V	LCERSS	URINA	RY PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	TRACT INFECT	IDNS 3) PLEUR	EL EFFU	SIONS	- '%'	* _ NO	OF DEATH?
z	4) PEPTIC VLCE		HYPOKA		_		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. Pt	ACE OF DEATH (Che	ck only one)		
PHYSICIAN:	1 TYES 2 TNO	Inpatient 2 ER/Outpatient 3		e 5 🗆 Residence	8 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day Year)		RK?	28d. DESCRIBE HOW	INJURY OCCURED	
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY — At home	1-1-1	res 2 No	281, LOCATION (Street	and Number or Price	Elborto Mombas
	4 Homicide 6 Could not be determined	building, etc. (Specify)	V/A		City or Town, State	N/A	Nodia Number,
COMPLETED	29e. CERTIFIER (Check only CERTIFYING PHYSICIA	AN: To the best of my knowledge, death	n occurred at the time date	and place, and due	to the cause(s) and ==	non an wand	
₩	one) 2 MEDICAL EXAMINER:	On the basis of examination and/or tree	restigation, in my opinion, d	eath occured at the	time, date and place, a	nd due to the ceuse	(e) and manner as stated.
l w l	295. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM			D (Month, Day, Year)
m	Mark to	meson	Mp		7	MAY	22.1945
유	30. NAME AND ADDRESS OF PERSON AND O	COMPLETED CAUSE OF DEATH (ITEM :	27) (Type, Print)	CENT	EP	. 11) (1113
	LA LA CALLACTOR	1500 PENNS	29 12012	AVES		TOWN, M	1021742
	MAV 9 3 1995	32 REGISTRAR'S SENATURE	_				

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permit. be detached for use as the burial-transit be retained by the hospital or attending physician. funeral director, page 5 should Раде 6 тау secuted within 24 hours after death.

In and completely filled in by the funera
to burial, cremation, or removal. it the death certificate be exe by the attending physician at and Mental Hygiene prior to Day t that

BALTIMORE, MARYLAND 21215-0020

BOX 68760

P.0.

DIVISION OF VITAL RECORDS,

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OR ATTENDING PHYSICIAN:

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GRONAFURE AND TITLE OF CERTIFIED

Pages 1, 2, 3 should

once, notified 3 must examiner medical 幸 event. traumatic other 10 Injury. any Signed Health a Shows t. of t has b 23 certificate I 0 marked, this After DIRECTOR: A hours after d -09 HOSPITAL (FUNERAL (WITHIN 72 H

95 15759 ITEM: 17. PER F.H. FILM G-723 5/23/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** ROBINSON MAY. 1995 20th 01:07 AM M S. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, B. BIRTHPLACE (State or Foreign Country) 215-07-7068 DAYS HOURS 1 XM 2 - F 80 July 31,1914 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL HOSPITAL ASSOCIATION
RESIDENCE OF DECEMENT GLEN BURNIE A.A. COUNTY 10b. COUNTY 10c. CITY, TOWN OR LOCATION toe. STATE 10d, INSIDE CITY LIMITS? Maryland Anne Arundel Pasadena 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7743 Outing Ave. 21122 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, atc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 ☐ YES 2 ☑ NO Specify: 1 Never Married 2 Merried Specify: White В 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Plant Operator WR. Grace Co. 9 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) GRAFTON ROBINSON BE -Woodrow Robinson Nellie (Unknown) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ms. Virginia Robinson 7743 Outing Ave. Pasadena, Md. 21122 20a. METHOD OF DISPOSITION

15 Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Glen Haven Mem.Park May 23,1995 Glen Burnie,Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home 3204 Mountain Rd. Pasadena, Md. 21122 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one course on each line. Approximate Interval Batwa IMMEDIATE CAUSE (Finel Onset and Death disease pr condition andri Dulheran 30 mins resulting in death) DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCTION CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEDE 1 TYES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural coldent 5 Pending 1 YES 2 NO ВY Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es atated. TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 _ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.

Waler DO5 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CADSE OF DEATH (UTEM 27) (Type, Print) SALVACION A. DUPAYA, M.D./1720 CRAIN HWY, S #204/GLEN BURNIE, MD 21061 MAY 23 1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TEM: 27,	PER DR.	FILM	G-727	9/14/	95 t	.t
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	FOR STATE REGISTRAR	STATE OF MARY!	AND / DEPART	MENT OF H	DEATH AND	MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) PQUINC L,	Rickel				MONT	OF DEATH D	9 19	YEAR 95	3 58 PM	
	4. SOCIAL SECURITY NUMBER 213-40-1078	1 M 2 KF 7	7 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	1 0 -	OF BIRTH	917	Country) MAS	LACE (State or Foreign SACHUSETT)	
TOR	99. FACILITY NAME (If not institution, give str GOOD SAMARITAN RESIDENCE OF DECEMENT				IMORE	EATH		9c. COUNTY	/ A	ATH	
DIRECTOR	10a. STATE 10b. COUNTY	N/A		CITY, TOWN OR LOCATION ALTIMORE					10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 6000 BELLONA A	VENUE		101	21212			U.S		AT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 FA			If yes, sp	ENDENT OF HISPAI ecify Cuban, Mexica 2 NO Specif	in, Puerto I	I? (Specify Yes Ricen, etc.)	or No- 14		- American Indien, White, etc.	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	(Give kind of wo						TRY			
	17. FATHER'S NAME (First, Middle, Last) MARTIN M. LALL		RESIDENT	DENT NURSE NURSING 16. MOTHER'S NAME (First, Middle, Melden Surname) ELIZABETH NOLAN							
TO BE	190. INFORMANT'S NAME (Type/Print) BARBARA SAUER	1 SK.			nd Number or Rural	Route Numb	ber, City or Town	n, State, Zip Co			
BARBARA SAUER 815 HAYDEN WAY BELAIR, MD. 21014 200. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) DULANEY VALUEY MEM. 5/95 COCKEYSU									y or Town		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE VILLEAM R. PAULIT 122. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 2121								•			
RIFICATION	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. MMEDIATE CAUSE (Final disease or condition resulting in death) MYD CAYDIA Infavc TDV										
CERTIF	that initiated events resulting in death) LAST PART II. Other significant conditions		A CONSEQUENCE OF):			Bart I					
MEDICAL							24a. WAS AN PERFOR 1 YES 2	MED?	C	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DEATH	(Check only one)							
	27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Outs 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ	JRY AT RK?		(Specify)	JURY OCCUR	RED .		
TED BY	2 Accident 3 Suicide 6 Could not be determined	Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)							ite Number,		
COMPLET		IAN: To the best of my know							ause(s) q	nd manner es stated.	
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	lag M	.0.		29c. LICENSE NUM	## 4	0	29d. DATE SI	IGNED (N	10rnh, Day, Year)	
	LIZA LAG 31. DATE FILED (Month, Day, Year)	GOOD 32 REGISTRARIS OGN	SAMAR		HOSPIT	NL,	BAL	-TIMOR	RE,	140 21239	
	MAY 2 3 1995 Jal	M COMPANDED	10.49								

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1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY MAGDALE MAMA 7:03 Pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign July 22, 1915 212-01-0262 HOURS 79 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR N/A St. Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 YES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 130 Symington Avenue funeral director, page 5 should be detached for use as the burial-transit 21228 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Not4. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried It yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Specify White 1 YES 2 THO BY Specify: 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

170-lim kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Haas Tailor's 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Nicholas Sernocky Martha Timcevicius BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Richard Raman 130 Symington Avenue Catonsville, Maryland 21228 attending physician and completely filed in by the funeral director, page 5 may be remarked Hygiene prior to burial, cremation, or removal. 9 20a_METHOD OF DISPOSITION
1 ABuriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Lakeview Memorial Park May 23,1995 4 Donation 6 Other (Specify) Sykesville, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSH 122. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Avenue Catonsville, Maryland 21228 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition MYBLODYSPLASTIC DISORDER 30 MONTHS reaulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST the death een signed by the atte injury. PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24e. WAS AN AUTOPSY requires that amy OBSTRUCTUR Pouronno Dz 1 YES 2 NO Shows OF OEATH? CONGRETUR ARMY FAILURE 1 | YES 2 | NO been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: State Dept. MB 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Item EXAMINER? HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT marked, 28d, DESCRIBE NOW INJURY OCCURED this c Natural 5 Pending DIRECTOR: After the hours after death w м 1 YES 2 ND BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 26t. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 8 Could not be COMPLETED 4 Nomicide CERTIFYING PNYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 h HOSPITAL 2 MEDICAL EXAMINER: Dn the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 29b. SGRATURE AND TITUE DE CERTIFIER 29d. DATE SIGNED (Month. Day, Year) BE 29c. LICENSE NUMBER 95 19 4001 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) MAY 2 3 1995 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Pages 1, 2, 3 should

BOX 68760

attending physician

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this certificate has been

BE

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29b. SIGNATURE AND TITLE OF CERTIFIER

1Sozhan

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typg-Print)

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RECORDS	requires
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OF VI	PHYSICIAN:
/ISION	ATTENDING
2	8
_	HOSPITAL

ITEM: 18. PER F.H. FILM G-723 5/23/95 t.t FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY 1995 1:24 PM 8. AGE (In vrs. last birth 7. DATE OF BIRTH (Month, Day, Year NOV. 15, IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 14 M 2 | F DAYS HOURS 218-44-9075 89 YES 1905 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Church Hospital Baltimore N/A RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maruland N/A Baltimore 1 YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 814 S. Eaton Street 21224 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 X Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only higher (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) N/A N/A Fire Fighter City of Baltimore 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Schafer notified at Henrietta Schruber SCHRIEBER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Arlene L. Lenning (Daughter) 814 S. Eaton Street, Baltimore, Md. og 20e, METHOD OF DISPOSITION
1 X Burlet 2 Cremetton 3 Removet from State
4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Parkwood Cemetery 5/22/95 Baltimore. Maryland medical examiner 21. SIGNATURBIOF, FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213 filled in by the tion, or removal. 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feliure. List only one ceuse on each line. interval Between Onset and Death completely filled rial, cremation, c **IMMEDIATE CAUSE (Final** the disease or condition Myocardial Injarction 12 Hours resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): and com Alheroscleso fic Cardio Vascula CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 Mental any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO signed by the Cardiogenic PERFORMED? Shock COMPLETION OF CAUSE 1 YES 2 4 NO shows a 1 YES 2 3 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO L'UNCERTAIN PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item State HOSPITAL: OTHER: 1 YES 2 PNO 1 Popularie 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) the 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY marked, 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with 1 Natural 1 YES 2 NO death Investigation BY DIRECTOR; After hours after death 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, oHica building, etc. (Specify) 60 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated. THE HOSPITAL C THE FUNERAL D filed within 72 ha TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

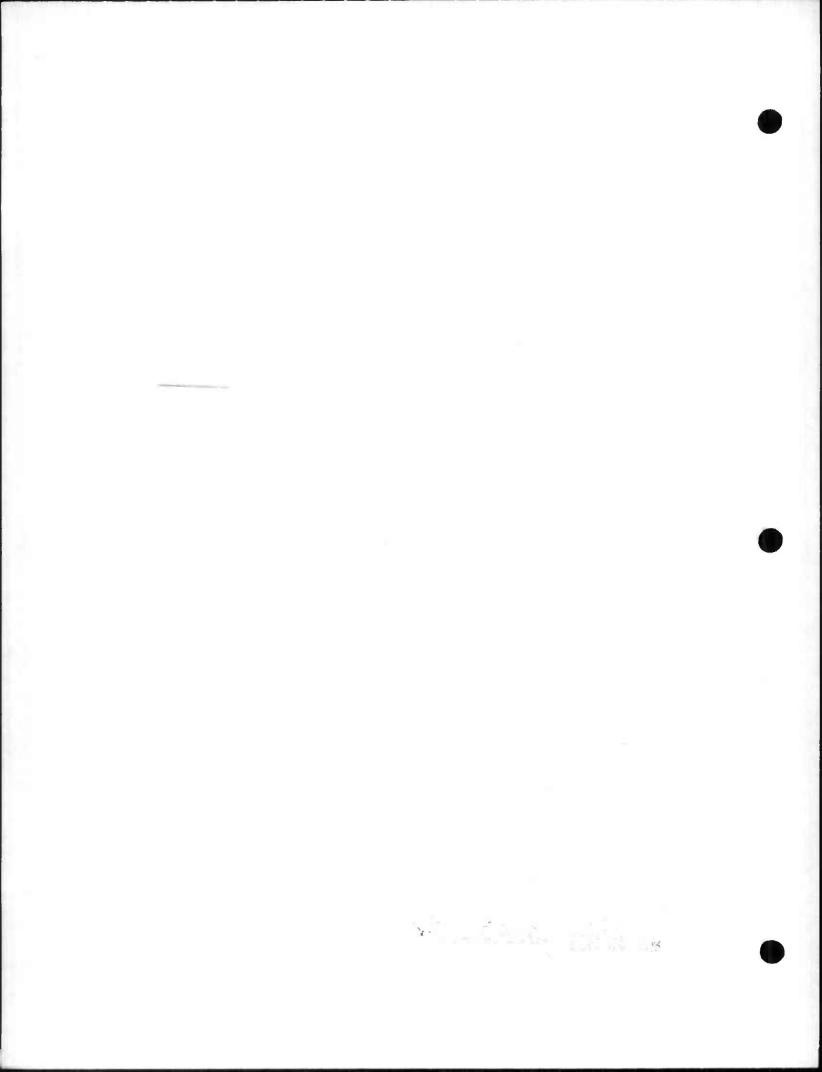
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13roadway 1- Sallimne mary Cand North 31. DATE FILED (Month, Day, Year) 32. REDISTRAR'S SIGNATURE

18 1995

29d. DATE SIGNED (Month, Day, Year)

May



DIRECTOR

FUNERAL

BY

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CERTIFICATION

MEDICAL

PHYSICIAN:

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MAY 2 3 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

John Shavers, M.D. 518 S. Camp Meade Rd. Linthicum, MD 21090

32 REGISTRAT'S SUNATURE

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or filem 23 shows any injury or other traumatic event the marked as marked.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 22 3. TIME OF DEATH 1995 Alfred (NMN) Stubbs 11:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign JUNE 19,1922 DAYS HOURS MIN. 219-16-8120 1 X M 2 - F Maryland YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH St. Joseph Hospital / E.R. **Baltimore** Towson RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Maryland Baltimore City 1 TYES 2 NO 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4700 Harford Road 21214 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? (X YES 2)
IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Second /Secondary (0-12) College (1-4 or 5+) Mechanic Automotive Maintenance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert R. Stubbs Araminta "Unknown" Chipchase 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Eveler RD#2, Box 2630 Spring Grove, PA 17362 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Metro Crematory, Inc. 05/23/95 Baltimore, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cremation Society of Maryland, Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heert fellure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Fine) Onset and Death disease or condition_ a. CASTOU, AND NA HOTO GRAITMIT resulting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate e. Enter UNDERLYING CAUSE (Diseese or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NOW UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO 2 Accident 26a. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. SHA SHONATURE AND TITLE OF CENTERS 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

OHMH-16 Rev 1/89

May 22, 1995

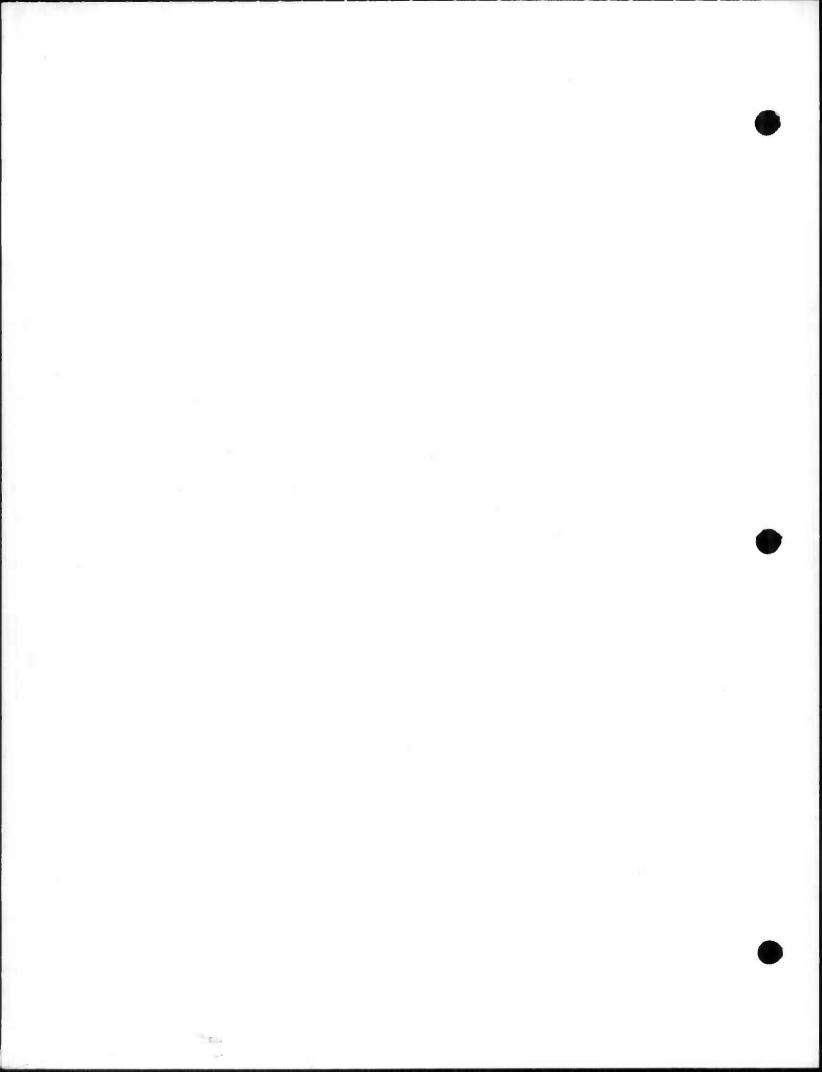
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1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	HEGISTHAN		- OL	CHILL	CAIL	PEAIN	RE	G. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest) AGATHA M CETREDT	AGATHA M SETREDT									
										1:05 p. m	
		4.4				IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day,	Month, Day, Year) 1909		LACE (State or Foreign	
	9e. FACILITY NAME (If not institution, give street	et and number)			9b. CITY, TOW	OR LOCATION OF D			UNTY OF DE		
8	Good Samaritan Ho	spital			Balt	imore		N/			
디	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c CITY	TOWN OR LO	ATION					
DIRECTOR	Maryland Baltin		timore	ATION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO				
A A	10e. STREET AND NUMBER					IOI. ZIP CODE		10g. CI		HAT COUNTRY?	
FUNERAL	5 Conoga Road, Ap	t. 10				21236		и	S.A.		
15	11. MARITAL STATUS 1 1 Never Married 2 Married	12. WAS OECEDENT EVE FORCES? 1 Y	ES 2 X N		13. WAS D	ECENDENT OF HISPAI	HC ORIGIN? (Spe	cify Yea or No—	14. RACE Black,	- American Indian, White, etc.	
B¥	3 🕅 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OF	DATES			ES 2 NO Specif		,	Specify		
once. COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co		(Gh	ve kind of w	JSUAL OCCUPA ork done during	TION most of working	16b. KIND	OF BUSINESS/IN	DUSTRY	WILCOLL	
님	Elementary/Secondary (0-12) N/A	College (1-4 or 5+)	IIIe.	DO NOT USE TILOT	retired.)		Tai	loring	Campa	10.11	
OM G	17. FATHER'S NAME (First, Middle, Last)	7//	1 10	uccon		18. MOTHER'S NA			сотра	ng	
a a	Louis Reibold						immerma				
TO B	19e. INFORMANT'S NAME (Type/Print)	th - 4 ' 0				t end Number or Rural					
8	Bill Seibert (Broz					Avenue,			212		
examiner must be notified at once. TO BE COM	1 \(\text{Buriel 2 } \) Cremation 3 \(\text{Removis} \) 4 \(\text{Donation 5 } \) Other (Specify)	al Irom State	206. PLACEA Cametery, cren GOLDE!	ND DATEO netory or oth ひる の有	F DISPOSITION (Cem. 5/	24/95	Baltim	OTC.	m, state Maruland	
- Line	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	/		Schi	AND ADDRESS OF FA	CILITY PHAR HO	m O	,		
	Matthe	MANT			3331	Brehms L	ane, Ba	ltimore	, Md.	21213	
100	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	mplications that cause or	sed the dec	eth. Do no	ot enter the n	node of dying, suc	h aa cardlec o	r reapiratory at	rreal,	Approximate Interval Between	
9	IMMEDIATE CAUSE (Final disease or condition	00-1	1	4						Onset and Death	
en.	resulting in death) s. ASPMX iatum DUE TO (OR AS A CONSEQUENCE OF):									minutes.	
or other traumatic event, the medical	Sequentially list conditions, Due to (or as a consequence of): Minutes										
ATIO	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	S A CONSEO	UENCE OF	32						
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR A	S A CONSEO	UENCE OF	:						
CERTIFICATION	resulting in death) LAST										
	PART II. Other significant conditions	contributing to deeti	but not re	eulting in	the underly	ng causa given in	Part I. 24a. V	WAS AN AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS	
EDICAL								YES 2 NO		MAILABLE PRIOR TO COMPLETION OF CAUSE	
SHOWS								7		OF DEATH?	
3 3	DID TOBACCO USE CONTRIB	BUTE TO CAUSE				UNCERTAIN	1 🗆				
PHYSICIAN:		HOSPITAL:			OTHER:						
H.	27. MANNER OF DEATH	26e. DATE OF INJUR	iy I	28b. TIME	OF 28c. I	me 5 Residence		NOW INJURY OC	CURED		
Marked, or Item BY PHYSICI	1 Natural 5 Pending 2 Accident Investigation	may 21,1	995	INJU	M 1	YES 2 NO	Aspira		food		
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJU building, etc. (S	inaciivi	me, term, at	reet, factory, of	Ice	City or Town	(Street and Number, Stete)		uto Number, El timore, MD.	
ŽE Z	29e. CERTIFIER 1 CERTIFYINO PNYSICIA	N: To the best of my kn			at the time de	to and place and dis-					
COMPLETED	(Check only one) 2 MEDICAL EXAMINER:									end manner ee stated.	
E H	Maurone C	Inedly	30-1			29c. LICENSE NUN D 4650				Month, Day, Year) 23, 1995	
2	Nancy Taldec. Fried	elley, MO	Cy UUT	en com	ia ni tan	Hospita		hmore.	man	land	
	31. MAY 2 3 1995 Jul	32 PEGISTRAR'S S			÷.	· ·		,			

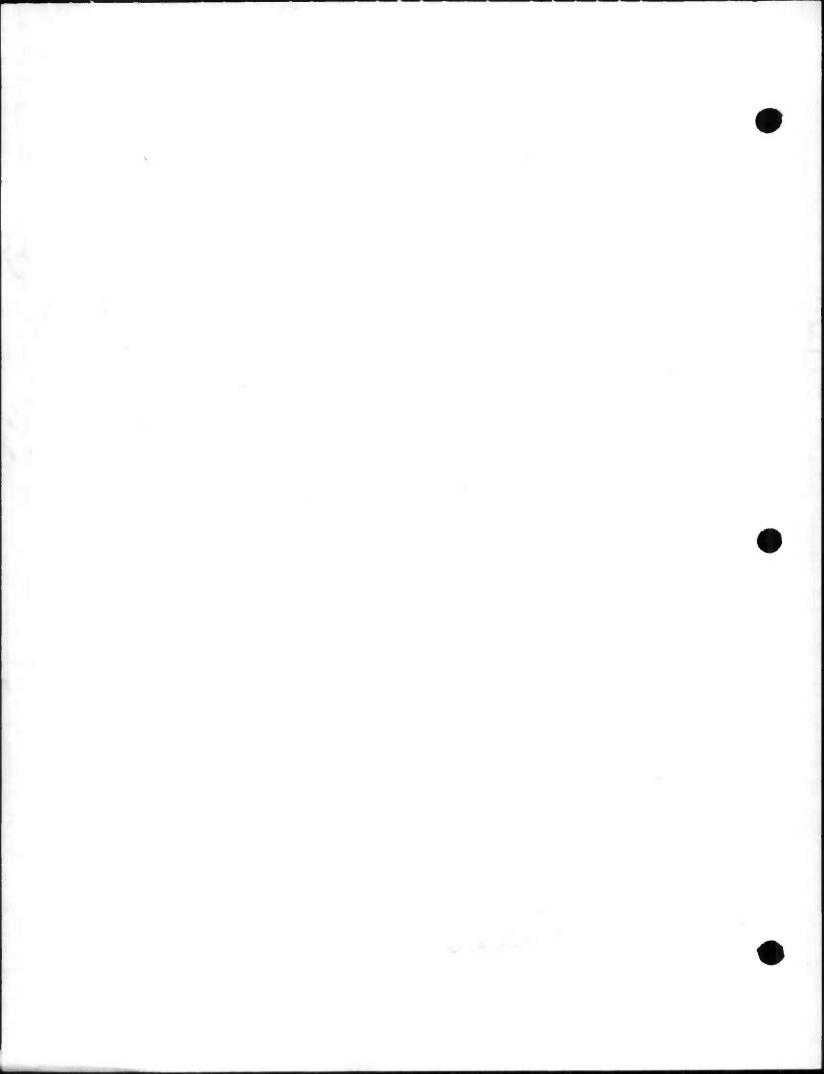


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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF CEATH
	WALTER B SMITH DAY YEAR 9 500 10 M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) 1 UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Months) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 7. PAR MONTHS DAYS HOURS MIN. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country)
	99. FACILITY NAME (If not institution, give street and gumber) 90. CITY, IDWN OR LOCATION OF DEATH 90. COUNTY OF DEATH
DIRECTOR	University Hospital Baltimore NA
H	100, STATE 10b, COUNTY 10d, INSIDE, CITY LIMITED
	Maryland 10/1 Daltinore 1 Dres 2 - NO
FUNERAL	3021 Arunah Ave, 21216 10g. CITIZEN OF WHAT COUNTRY?
5	11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 1 Never Married 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, White, etc.
BY	3 Wildowed 4 Divorced IF YES GIVE WAR OF DATES 1 YES 2 THO Specify: Specify:
E I	15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KINO OF BUSINESS/INDUSTRY
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) Ille. Do NOT, use refired.)
i S I	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)
BE (Walter Brewster Smith Carrie Lark
2	19th. INFORMANT'S NAME (DiperPrint). 19th. MAILING ADDRESS (Street end Number or Purel floute Number, City or Town, Shets, Zip Code) 3021 Ar 1100 By At 2 M1 2/2/6
	20e_METHOD OF DISPOSITION 1 M Burlai 2 Cremation 3 Removal from State 20e_METHOD OF DISPOSITION (Name of Date Date Of Disposition (Name of Date Date Date Date Date Date Date Date
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FAME AND
	Joseph L. Russ Funeral Home
	23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	/shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Death
	disease or condition resulting in death) a. CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF):
	The state of the s
S S	Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):
ATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C. CAUSE (Disease or Injury C. CAUSE (Disease or Injury)
윤	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):
CERTIFICATION	resulting in death) LAST
	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS
EDICAL	PERFORMED? AVAILABLE PRIOR TO
ED	1 U YES 2 DNO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)
Sic	EXAMINER? HOSPITAL: OTHER:
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW IN HIRTY OCCURRED
ВУ Р	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO
	3 Suicide 4 Homicide 8 Could not be determined determined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
9	29e. CERTIFIER
COMPLETED	(Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner es stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(a) end menner es stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)
2	20 NAME AND \$1/18/95
	Glynis A Moody, MO University of Maryland 225. Gineene Street Rettiment MO 21201
	31. DATE FILED (Month, Day, Your) 12. REGISTRAR'S SIGNATURE 1. DATE FILED (Month, Day, Your)
	THE CITY OF THE COURSE OF THE



TO THE HOSPITAL, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

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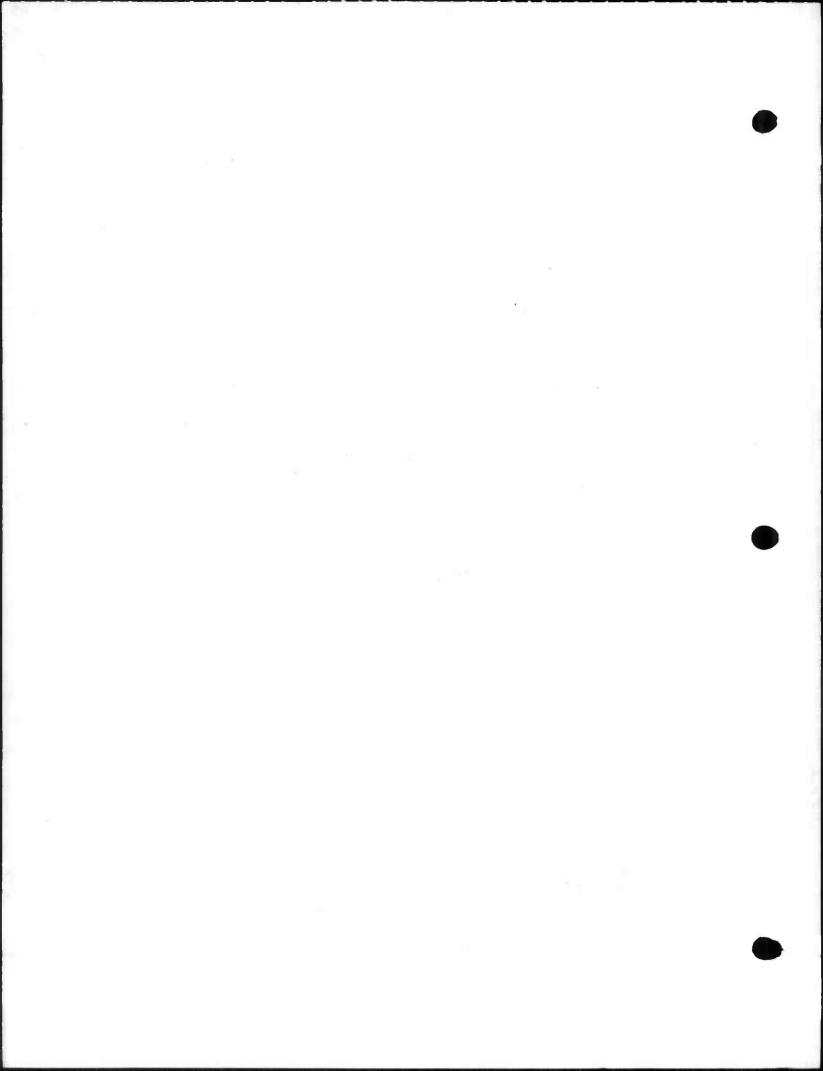
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH	
ITEMS:	24a,25,26,27,29a, PER FACILITY FILM G-723.5/23/95 t	

	REGISTRAR	CERTIF	ICATE OF DEATH	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest) ROBERT SIMMONS JR.			2. DATE OF DEATH MONTH DAY	1995	3. TIME OF DEATH 4:30A			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreign			
	213-28-2868 ¹¼м₂□F	66 vrs.	MONTHS DAYS HOURS MIN.	JULY, 1028	, 29 FLO	KIDA			
Œ	9a. FACILITY NAME (if not institution, give street and number) VAMC, FORT HOWARD	_	9b. CITY, TOWN OR LOCATION OF DE	ATH	9c. COUNTY OF	DEATH			
DIRECTOR	RESIDENCE OF DECEDENT		BALTIMORE		CITY				
H.	10a. STATE 10b. COUNTY			10d. INSIDE CITY LIMITS?					
	MARYLAND CITY	BA	LTIMORE			1 X YES 2 NO			
FUNERAL	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
N.	4851 HAZELWOOD AVE, 11. MARITAL STATUS 12. WAS DECEDENT EVER	IN II S. ADMED	21206	10 00101110 m - 14 V	USA				
B	1 Never Married 2 Married FORCES? 12 YS, GIVE WAR OF 1950 — 195	S 2 NO	If yes, specify Cuban, Mexica 1 YES 2 X NO Specify	n, Puerto Rican, etc.)	Blac	E — American Indian, ck, White, etc. chy: ERICAN, BLACK			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S (Give kind of v	USUAL OCCUPATION work done during most of working e retired.)	16b. KIND OF BUSI					
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 +)		GOVERNMENT	FORT CE	ORGE G.	MEADE			
WO	17. FATHER'S NAME (First, Middle, Last)	TEDLICAL		ME (First, Middle, Meiden S		MEADE			
BEC	ROBERT SIMMONS SR.		BERTHA	SIMMONS	Jorramey				
TO B	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street and Number or Rural F	loute Number, City or Town,	, State, Zip Code)				
F	WANDA S. SAUNDERS	4851	HAZELWOOD AVE, B	ALTIMORE,	MARYLANI	21206			
	4 Donation 5 Other (Specific	ob. PLACE AND DATE COMPLETY OF OUT	OF DISPOSITION (Name of the class) VETERAN CEMETERY	DATE 20c. LOC 4 5/22/95	CROWNSVI	Own, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	\supset	22. NAME AND ADDRESS OF FAMESTEP BROTHERS 1300 EUTAW PLA	FUNERAL H					
	23. PART i. Enter the disease, or complications that cause	ed the death. Do n	ot sater the mode of dying, such	ss cardiec or respir	atory srrest,	Approximate			
	ahock, ph/heart fallure. List only one cause on IMMEDIATE CAUSE (Finel	each ilne.				Interval Between Onset and Death			
	disease or condition ADENO, CARCINOMA OF COLON 2 years								
	DUE TO (OR AS A CONSEQUENCE OF):								
O	Sequentially list conditions,	ASIS TO L. A CONSEQUENCE OF	IVER AND LUNGS			2 years			
CAT	if any, leading to immediate cause. Enter UNDERLYING	OMY AND R	ADIATION THERAPY			3 months			
CERTIFICATION		A CONSEQUENCE OF							
H H	d								
	PART II. Other eignificent conditione contributing to deeth	but not resulting i	n the underlying cause given in	Pert i. 24s. WAS AN A		b. WERE AUTOPSY FINDINGS			
EDICAL				1 D YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?			
Σ				_ [1 TES 2 NO			
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERRED TO MEDICAL			1 🗆					
Si	EXAMINER? HOSPITAL:	26. PLACE OF DEAT	OTHER:	12					
PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF INJUR	Y 28b, TIMI	4 Nursing Home 5 Residence OF 28c. INJURY AT	8 ☐ Other (Specify) 28d. DESCRIBE HOW IN.	JURY OCCURED				
ВУ Р	1 Netural 5 Pending (Month, Day, Year 2 Accident Investigation) INJ	M 1 YES 2 NO		oon oodines				
	3 Suicide 6 Could not be determined 28e. PLACE OF INJU building, atc. (S)	RY — At home, farm, a pecify)	treet, factory, office	26f. LOCATION (Street an City or Town, State)	nd Number or Rural	Route Number,			
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my known one) 2 MEDICAL EXAMINER: On the beat of examinar					a) and manner se stated			
	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM			D (Month, Day, Year)			
) BE	Augustine Chrisu-	11-D	7-18	298	> man				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF AUGUSTIN CHYU, M.D., 9600 NO	RTH POINT	ROAD, FT. HOWAR	D, MD. 2105	52	11.1.0			
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG								
	MAY 2 3 1995 July Student	1.11							



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.

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	L.R.B.								9:		5/6/
	1 - FOR STATE REGISTRAR	STATE OF I				DF HEALTH OF DEA		MENTAL HYGII			
								2. DATE OF DEATH		1 3	. TIME OF DEATH
1 8	DONALD		JOSEPI	Н	ç	SWAIN		MAY 19	1995	YEAR	2:00A M
	4. SOCIAL SECURITY NUMBER	5. 9EX	6. AGE (In yrs. Is		IF UNDER 1		R 24 HRS.	7. DATE OF BIRTH	1		ACE (State or Foreign
	215-76-4200	1X M 2 . F	32	YRS.	MONTHS E	DAYS HOURS	MIN.	Sept. 1	4 1962	Country)	ryland
	9a. FACILITY NAME (If not institution, give a	treet and number)			95 CITY T	OWN OR LOCAT	ION OF D			IVICIT	,
Œ					, so, Giri, i						
16	I-695 @ EXIT	133				VVI	iite	Marsh	BAI	LTIMO	ORE.
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATION				1	Od. INSIDE CITY
8	Maryland Ca	rroll		L	inebo	ro				1	LIMITS?
A	10e. STREET AND NUMBER					10f. ZIP COD	E		10g. CITI		AT COUNTRY?
FUNERAL	4223 Main Stree	et				210	88		U:	SA	
S	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. A	RMED	13. WA	S DECENDENT	OF HISPAN	VIC ORIGIN? (Specify	Yes or No.	14 BACE -	- American Indian,
	1 Never Merried 2 Merried		YES 2 2	K NO	lf y	es, specify Cubi	en, Mexica	n, Puerto Rican, etc.)		Black, \	White, etc.
BY	3 Widowed 4 Divorced				1	_ 120 1 X 110	O(POCH)	,.		Specify:	White
COMPLETED	15, DECEDENT'S EDU/ (Specify only highest grade		16a. D	ECEDENT'S	USUAL OCC	UPATION ing most of worki		16b, KIND OF	BUSINESS/IND	USTRY	
9	Elementary/Secondary (0-12)	Coffege (1-4 or 5		Do NOT us	ie retired.)		ny				
₩	11	NIA		Elect	rician			Comme	rcial	Buildi	ing
181	17. FATHER'S NAME (First, Mickin, Last)							ME (First, Middle, Meid			
BE	Charles M. Swain	1				Fr	ance	s A. Mic	hael		
2	19s. INFORMANT'S NAME (Type/Fort)	19	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zlp Code)								
=	Daniel M. Swain			901 Rosedale Ave., Baltimore, MD 21237							
1 1	20s. METHOD OF DISPOSITION OC Burlel 2 Cremation 3 - Rem	mind from State			OF DISPOSITI	DN /Name of		DATE 20c.	LOCATION —	City or Town	, State
1 1	4 Donation 5 Diher (1960)		Oakl	awn	Cemet	erv		5/23 B	altimo	re. M	D
1 1	21. SIGNATURE OF SUMMAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
1.4	Lowell M. A.	Amment of	dones	m				eral Hom			
\vdash	23 DAST I Enter the diseases of complications that county the destination in the county of the count										
									interval Between		
	IMMEDIATE CAUSE (Finel disease or condition	. 111								Onset and Death	
1 1	disease or condition resulting in death) a.										
_	The state of the s										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):									-	
X	cause. Enter UNDERLYING										
트	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	7):						
E	resulting in deeth) LAST										
岁											
¥	PART II. Other algnificent condition	a contributing to	death but not	reaulting i	n tha unde	rlying ceuse	given in	Part i. 24a. WAS.	AN AUTOPSY ORMED?		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
MEDICAL									2 NO	C	OMPLETION OF CAUSE F DEATH?
W											KYES 2 NO
	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	ATH YE	S I NO	ONU INC	ERTAIN	10			
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				H (Check onl)						
)S	NO NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	Home 5 🗆 Re	sidence	(Specify)	нтаны	N V	
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF (Month, D	INJURY	28b. TIM		c. INJURY AT		28d. DESCRIBE HON			
BY F	1 Netural 5 Pending 2 Accident Investigation		9-95	004	URY	WORK?	KNO	motor uch	sich co	Misson	1
	3 Suicide 8 Could not be	28e. PLACE O	F INJURY At he etc. (Specify)			office		284 LOCATION (Stee	at and Mumbar	or Gund Bou	to Africa have
12	4 Homicide determined		\$	treet				Bultimare	(0. H		XIF 30
COMPLET	29e. CERTIFIER (Check only	CIAN: To the beat of	my knowledge d	eath occurre	d at the time	data and niece	and due	to the cause(e) and n			
N N	one) 2 MEDICAL EXAMINE										nd menner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER										
29c. LICENSE NUMBER						RER	29d. DATE	SIGNED (M	ionth, Day, Year)		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201.

O.C.M.E

31. DATE FILED (Month, Day, Year) MAY 2 3 1995 31 REGISTRAR'S GNATUR

hute m

296. SIGNATURE AND TITLE OF CERTIFIER

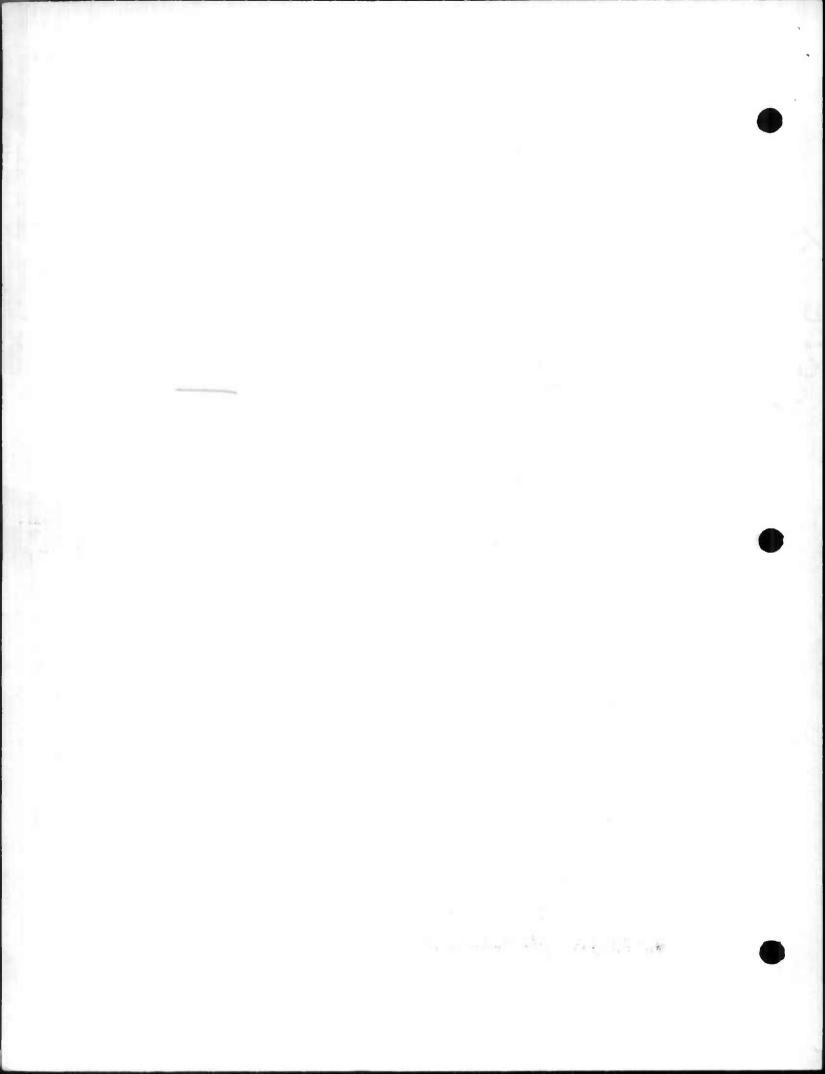
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1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IN THE FUNE FIGURE AND THE THIS THIS THIS THIS THIS THIS THIS THIS	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	1880007887 6 House 30 to mendered on Steam 29 schools described the second of the second to a second to a second to a second
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	ITEM: 18. PER F.H. F	1LM G-723 5/23	7/95 t.t				9	5 15768	
	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEAL		AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)				2. D/	TE OF DEATH		3. TIME OF DEATH	
	TROY H. STONER MAY 12							5 1405 M	
		1 M 2 D F 8		F UNDER 1 YEAR IF U	PES MIN. (M	TE OF BIRTH onth, Day, Year)		BIRTHPLACE (State or Foreign Country) INDIANNA	
0	9s. FACILITY NAME (If not institution, give stre			b. CITY, TOWN OR LO	CATION OF DEATH			Y OF DEATH	
DIRECTOR	WORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUN								
IREC	10a. STATE 10b. COUNTY		10c, CITY,	TOWN OR LOCATION 10d. INSIDE CITY LIMITS?					
	MARYLAND ANNI 100. STREET AND NUMBER	E ARUNDEL	GI	LEN BURNIE 1 TES 2 X NO					
ERA	402 AQUAHART I	ROAD		,	21061			N OF WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDE	NT OF HISPANIC ORI	GIN? (Specify Yes		I. RACE — American Indian, Black, White, etc.	
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA		1 Tes 2	Cuban, Mexican, Puer NO Specify:	to Hican, etc.)		Specify: WHITE	
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	TION ompleted)	16a. DECEDENT'S US (Give kind of wor	k done during most of v	working	16b. KIND OF BUS	INESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	BOSS F	•		S	TEEL C	COMPANY	
OM	17. FATHER'S NAME (First, Middle, Last)		2000 1		MOTHER'S NAME (Fir				
BE 0	GEORGE STONE	ER			CORA	Unknown	HAIN	ES	
2	19st. INFORMANT'S NAME (Type/Print)		1	DDRESS (Street and Nu					
	MARY L. STONER 20s. METHOD OF DISPOSITION	20h	PLACE AND DATE OF	DISPOSITION (Name of				061 y or Town, State	
	1 Burisi 2 Cremation 3 Remov	ral from State ceme	etery, crematory or other	r place!	1			E, MARYLAND	
	21. BIGNATURE OF PUNERAL SERVICE LICE	NSEE /		22. NAME AND AD	DRESS OF FACILITY				
	1 Collys >	Hailes		12134 WTI	-ASHTON F	VG RD.	BATT.	MD 21222	
	23. PART I. Enter the diseases, or co ahock, or heart fallure. Li	mplications that caused at only one cause on as	the death. Do not sch lina.	enter the mode of	f dying, such aa c	erdiac or reapli	ratory arrea	Approximate	
	IMMEDIATE CAUSE (Final disease or condition	DIVELA	MALLA					Onset and Death	
	disease or condition resulting in death) PINEWWNIA DUE TO (OR AS A CONSEQUENCE OF):								
z	Sequentially list conditions.								
101	Sequentially list conditions. b.							V	
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					V	
LIFICATIO	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		CONSEQUENCE OF):						
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury							V	
빙	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	the underlying ceu	iae given in Part i.	24e, WAS AN		24b. WERE AUTOPSY FINDINGS	
뮝	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other aignificent conditione	DUE TO (OR AS A contributing to death but	CONSEQUENCE OF):	the underlying cou	iae given in Part I.		MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other aignificent conditions THE TENSION REVAL PALL	DUE TO (OR AS A contributing to death but	consequence of):			PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other aignificent conditione PART II. Other aignificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERRIED TO MEDICAL	contributing to death but	consequence of):	□ NO □ U	iae given in Part I.	PERFORI	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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뮝	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other significent conditione PART II. Other significent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERRIED TO MEDICAL EXAMINER? 1	Contributing to death but BUTE TO CAUSE OF	CONSEQUENCE OF): ut not reculting in F DEATH YES 26. PLACE OF DEATH	(Check only one) OF HER: Sec. INJURY 3 WORK?	NCERTAIN Residence 6 0	PERFORI	MED? NO	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 ☑ NO	
BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditione PART II. Other algnificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERVIED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	Contributing to death but to CAUSE OF C	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH atlent 3 DOA 4	(Check only one) ITHER: Nursing Home 5 (DF) WORK? M 1 YES	Residence 6 0	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditione PART II. Other algnificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERVIED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	DUE TO (OR AS A contributing to death but BUTE TO CAUSE OF CONTRIBUTE TO CAUSE OF CONTRIBUTE TO CAUSE OF IT IN INTERPRETAL: CONTRIBUTE TO CAUSE OF INJURY	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH 28b. TIME C INJUR At home, form, stre	(Check only one) ITHER: Nursing Home 5 (DF) WORK? M 1 YES	Residence 6 0 O	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW IN	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 ☑ NO	
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ETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other significent conditione PART II. Other significent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERRIED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF BUTE	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH atlent 3 DOA 4 28b. TIME C INJUR At home, farm, stree fly)	Check only one) THER: Nursing Home 5 WORK? WORK? 1 YES et, factory, office	Residence 6 0 O	PERFORI 1 YES 2 Ther (Specify) DESCRIBE HOW IN DOCATION (Street at lay or Town, State)	NO NO NUMBER OF THE RESERVENCE	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other significent conditione PART II. Other significent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERRIED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF BUTE	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH atlent 3 DOA 4 28b. TIME C INJUR At home, farm, stree fly)	Check only one) THER: Nursing Home 5 Nursing Home 5 WORK? 1 YES et, factory, office at the time, date and p	Residence 6 0 O	PERFORI 1 YES 2 Ther (Specify) DESCRIBE HOW IN DOCATION (Street at lay or Town, State)	NO NO NUMBER OF THE PARTY OCCUS	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
E COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditione PART II. Other algnificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERVIED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF BUTE	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH atlent 3 DOA 4 28b. TIME C INJUR At home, farm, stree fly)	Check only one) OF Sec. INJURY MORK? The Sec. INJURY The	Residence 6 0 T 26d. t 2 NO 28f. L C	PERFORI 1 YES 2 Ther (Specify) DESCRIBE HOW IN DOCATION (Street at lay or Town, State)	NO NO NUMBER OF THE PARTY OCCUS	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERVIED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF HOSPITAL: Impatient 2 ER/Output 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, stc. (Special Contribution) AN: To the beat of my knowled On the basis of examination	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH 28b. TIME C INJUR At home, farm, streetly edge, death occurred a snd/or investigation,	Check only one) OF Sec. INJURY MORK? The Sec. INJURY The	Residence 6 0 T 26d. t 2 NO 28f. L C	PERFORI 1 YES 2 Ther (Specify) DESCRIBE HOW IN DOCATION (Street at lay or Town, State)	NO NO NUMBER OF THE PARTY OCCUS	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificent conditione DID TOBACCO USE CONTRI 25. WAS CASE REFERVIED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS A Contributing to death but BUTE TO CAUSE OF HOSPITAL: Impatient 2 ER/Output 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, stc. (Special Contribution) AN: To the beat of my knowled On the basis of examination	CONSEQUENCE OF): ut not reculting in F DEATH YES 28. PLACE OF DEATH 28b. TIME C INJUR At home, farm, streetly and/or investigation, OFF C ATURE	Check only one) OF Sec. INJURY MORK? The Sec. INJURY The	Residence 6 0 T 26d. t 2 NO 28f. L C	PERFORI 1 YES 2 Ther (Specify) DESCRIBE HOW IN DOCATION (Street at lay or Town, State)	NO NO NUMBER OF THE PARTY OCCUS	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number,	



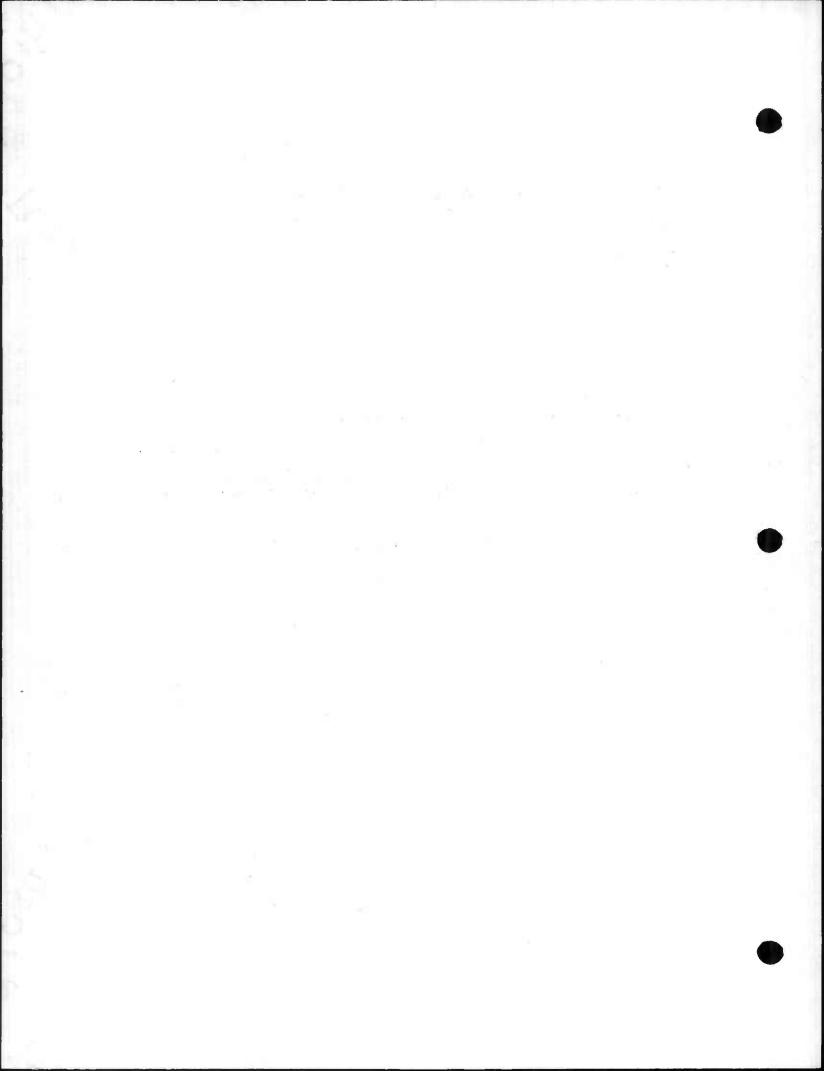
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ANNA SIEGEL S. MAY 19,1995 12:45 P M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS HOURS 1 M 2 FF YRS. OCT. 7, 219-18-2382 89 RUSSIA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1801 E. JEFFERSON ST. APT. 513 ROCKVILLE MONTGOMERY 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND MONTGOMERY ROCKVILLE 1 YES 2XXNO permit. 10a, STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? completely filled in by the funeral director, page 5 should be detached for use as the burial-transit 1801 E. JEFFERSON STREET 20852 U.S.A. APT. 513 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: WHITE BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5 TEACHER **EDUCATION** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) REV. ISAAC 76 SIEGEL SOPHIE **GREENHOUSE** BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. RICHARD STAHL 9108 HAMILTON DR., FAIRFAX, VA. 22031 2 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must AHAVAS SHALOM 5/21/95 BALTIMORE, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215 medical 23. PART I. Entar the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death the cremation, atheroschentic heart disease disease or condition resulting in death) 20 415 event, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to burial, traumatic hypertension DUE TOTOR AS A CONSEQUENCE OF): CERTIFICATION and Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST 0 shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TES NO OF DEATH? 1 TYES 2 NO has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\infty}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) tem After this certificate death with the State HOSPITAL OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 Bealdence 6 ☐ Other (Specify) 9 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicida 26t. LOCATION (Street and Number or Rural Route Number, City or Town. State) 69 ETED 6 Could not be DIRECTOR: after 4 Homicide 28 determined Hem 29a. CERTIFIER (Check ank I Check and I Check ank I Check and I Ch COMPL TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M IMPORTANT: If It 2 ___ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursed at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER 035103 2 PENSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6240 Montrose Kd Rockille re 73 ~ 32. REGISTRAR'S SIGNATURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whours after than the first	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, to burish to burish to burish the certain or removed.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
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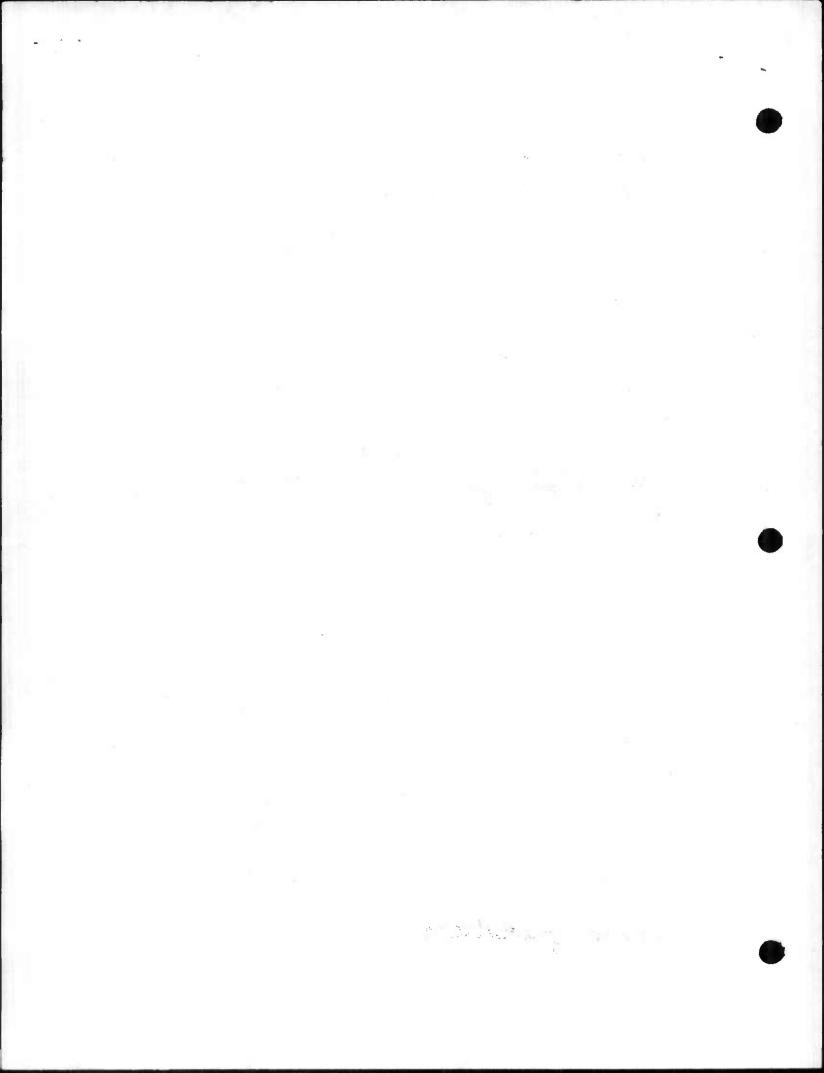
32 REGISTRAR'S SIGNATURE

	REGISTRAR		CERTIFI	CATE OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH	11000	3. TIME OF DEATH	
	MELVIN	Sce	ott		5 14	95 PAR	1/30 P	
	4. SOCIAL SECURITY NUMBER 217-94-4375		(In yrs. last birthday) YRS.	F UNDER 1 YEAR F UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIFTH (Month, Day, Your)	8. BIRTH Countr	APLACE (State or Foreign	
	9a. FACILITY NAME (If not institution, give at	reet and number)		96. CITY, TOWN OR LOCATION OF	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	e. COUNTY OF D	1.777	
СТОВ	Seton Hill RESIDENCE OF DECEDENT	MANOR		BALTIMOR	e l	NT	4	
DIRE	10e. STATE 10b. COUNTY	NA	10c. CITY	TOWN OR LOCATION A HIMORE			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	5610 GROUEL	400		2/2/.	5	10g. CITIZEN OF V	WHAT COUNTRY?	
BY FUR	11. MARITAL STATUS 1 Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DECENDENT OF HISP. If yes, specify Cuban, Maxic 1 YES 2 Ng Specific	can, Puerte Rican, atc.)	No — 14. RACE Black	LIAP A.L.	
8	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S L	ISUAL OCCUPATION	16b. KIND OF BUSIN	FSS/INDUSTRY	KAPTO MARA	
PLET	(Specify only highest grade :	College (1-4 or 5+)	(Give kind of wallife. Do NOT use	ork done during most of working	Geoc			
ŏ	17. FATHER'S, NAME (First, Middle, Last)	,	1414	16. MOTHER'S N	AME (First, Middle, Meiden Su			
ш	Melvin Scott	Sr.		DAI	sy Scott			
TO B	19a. INFORMANT'S NAME (Type/Print)	4	196. MAILING /	ADDRESS (Street and Number or Rura		State, Zip Code)	, 21217	
	20a METHOD OF DISPOSITION	206	PLACEAND DATEO	FDISPOSITION (Name of	QATE 20c. LOCA	TION — City or To		
	1 Suriel 2 Cremation 3 Remo	val from State com	retery, crematory or oth	er place)	3/8/2			
	7.1/7. X110200000 1110							
L	22. NAME AND ADDRESS OF FACILITY Wallace FUNDER Service 3405 W. Franklinst Boulding, Macy and 21229							
	23. PART LEtter to diseases, or conshock, or heart failure. L	list only one cause on e	ach ilne.	t enter the mode of dying, su	ch se cardisc or respirat	ory strest,	Approximata interval Between Onset and Death	
	disease or condition resulting in death)	OUE TO (OR AS A	CONSEQUENCE OF	mune Déficie	ncy Tyno	leome.	molte	
z								
Z	Constant the second			U	70			
CATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF)		70	,		
TIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	•	CONSEQUENCE OF)	0	J 0	9		
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	•		0	J ()	y		
L CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF)		J U	9		
	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)		1 Part I. 24a. WAS AN AU PERFORME	TOPSY 24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO	
EDICAL (if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF)		1 Part I. 24a, WAS AN AU	TOPSY 24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF)		1 Part I. 24a. WAS AN AU PERFORME	TOPSY 24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL	DUE TO (OR AS A	CONSEQUENCE OF)	the underlying ceuse given is	1 Part I. 24a. WAS AN AN PERFORME	TOPSY 24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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ED BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	DUE TO (OR AS A contributing to deeth be contributing to deeth be contributing to deeth be contributing to deeth be contributing to deeth be contributing to deeth be contributing to deeth be contributed to deeth be contrib	ut not resulting in	the underlying ceuse given in 26. PLACE OF DEATH (COTHER: Nursing Home 5 Residence OF 28c, INJURY AT WORK? M 1 YES 2 NO	Part I. 24a. WAS AN AU PERFORME 1 YES 2	TOPSY 246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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ETED BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	DUE TO (OR AS A contributing to deeth be HOSPITAL: 1 Inpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Special.)	ut not resulting in atlent 3 DOA 28b. TIME INJU	26. PLACE OF DEATH (COTFIER: Nursing Home 5 Residence OF 28c, INJURY AT WORK? M 1 YES 2 NO eet, factory, office	Part I. 24a. WAS AN AU PERFORME 1 YES 2 **Describe How Injuted City or Town, State) a to the cause(a) and manner	TOPSY 24b. O? NO PRY OCCUREO Number or Rural R	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
MPLETED BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1	DUE TO (OR AS A contributing to deeth be HOSPITAL: 1 Inpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, atc. (Special.)	ut not resulting in atlent 3 DOA 28b. TIME INJU	26. PLACE OF DEATH (COTFIER: Nursing Home 5 Residence OF 28c, INJURY AT WORK? M 1 YES 2 NO eet, factory, office at the time, data and place, and du	heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJL 28f. LOCATION (Street and City or Town, State) to the cause(a) and manner or time, date and piece, and described in the cause of time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time.	TOPSY 24b. O? NO PRY OCCUREO Number or Rural R	WERE AUTOPSY FINOINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A contributing to deeth be contributing to deeth be deeth be HOSPITAL: 1 Inpetlent 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special Control of the best of my known) in the basis of examination	ut not resulting in atient 3 □ DOA 28b. TIME 28b. TIME INJU — At home, farm, ste	26. PLACE OF DEATH (COTTHER: Nursing Home 5 Residence OF 28c. INJURY AT WORK? M 1 YES 2 NO set, fectory, office at the time, data and place, and du In my opinion, death occured at the	heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJL 28f. LOCATION (Street and City or Town, State) to the cause(a) and manner or time, date and piece, and described in the cause of time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time, date and piece, and described in time.	TOPSY 24b. NO 24b. IRY OCCUREO Number or Rural R	WERE AUTOPSY FINOINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,	
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

•		FOR STATE		STATE OF	MARY							MEN'	TAL H	YGIEN	E		
	!	REGISTRAR 1. DECEDENT'S NAME (First)			-	C	ERTIF	ICATE	E OF	DEA	TH		ATE OF E	- DI		YEAR	3. TIME OF DEATH
	ı			LLIVAN									AY	1	9,19	95	0840 A M
	ı	4. SOCIAL SECURITY NUME		5. SEX	6. AGE	(in yrs. le:	st birthday)	IF UNDER			R 24 HRS.		TE OF B			8. BIRTI	HPLACE (State or Foreign
	1	370-24-8231		1 🔀 M 2 🗌 F	6	6	YRS.	MONTHS	DAYS	HOURS	MIN.	Ju:		, 19		Mar	yland
000		9a. FACILITY NAME (If not in									ION OF DI				9c. COU	NTY OF E	DEATH
ECTOR		1323 EUTA	W PLA	CE-IST	FLC	OR	APT.	BA.	LTI	MORI	E CI	TY			_Bal	timo	ore City
DIRE	1	10a. STATE	10b. COUNTY	1			10c. CIT	Y, TOWH C	OR LOCAT	ION							10d. INSIDE CITY LIMITS?
		Maryland 100, STREET AND NUMBER					E	alti	-								1 XXYES 2 □ NO
RAL			D1						101	ZIP COD							WHAT COUNTRY?
FUNER	ŀ	1323 Euta	W Plac	12. WAS DECEDER	IT EVED	IN U.O. AE	MED	1 40 1	WA 0 000	212						ISA	
		1 Never Married 2	Married	FORCES?	X YES	2 🔲		1 1	if yes, sp	ecify Cub	OF HISPAN	ın, Puer	to Rican	, etc.)	or No-	Blac	E — American Indian, k, White, etc.
B		3 Widowed 4 Dive	rced	IF 7ES, GIVE	mn on i	DATES	WW 2	1	I _ YES	S M NO	Specify	у:				Spec	White
			EDENT'S EDUC y highest grade			(G	CEDENT'S	work done o	CCUPATIO	ON st of worki	ina		16b. KINI	OF BUS	SINESS/INC	DUSTRY	
LET		Elementary/Secondary (0		College (1-4 or 5	+)	170	. Do NOT u	retired.)	-		-						
OMPL COMPL	1	17. FATHER'S NAME (First, M		4 years		ובע	recto	r		40.000	110000 114			_	ion	WBAI	
E S		Walter R.		van							HER'S NA Len]			, Maiden	Surname)		
B	I	19a. INFORMANT'S NAME (7)		Vali	_	19	b. MAILING	ADDRESS	(Street a		_		_	lty or Town	n, State, Zic	Code)	
Mr. Michael Sullivan 7 Helms Pick Ct. Catonsville, MD 21228								28									
								own, State									
Ē	1	4 Donation 5 Other	(Specify)		_ Di	ruid	Ride	e Ce	e Cemetery 5-					Pik	cesvi	11e,	Maryland
examiner must	1	21. SIGNATURE OF FUNERAL	SERVICE LIC	PENSEE									ral	Dir	ecto	rs.	Inc
	1	John	K A	you	~			87	28 I	iber	tv B	Rd.	Ra	ndal	leto	1.7T	
event, the medical		23. PART . Enter the di ahock, or hi IMMEDIATE CAUSE (Fin disease or condition resulting in death)	aart fallUre, l	a. AH	iew	sch ilns	Ú.	Ca								rest,	Approximate interval Between Onset and Death
				DUE 10	(OH AS	A CONSE	QUENCE O	F):									
y, or other traumatic		Sequentially list conditi if any, leading to immediate. Enter UNDERLY!	diate	DUE TO	(OR AS	A CONSE	QUENCE OF	F):									
TIFIC		CAUSE (Disease or inju		DUE TO	(OR AS	A CONSE	GUENCE OI	F):	_								-
EH C	ı	reaulting in death) LAS	т [,	4.				•									į
3		PART II. Other algnifica	nt condition	a contribution to	doeth I	hart mate		lm ébo sum	el - els (l = -			ent to 1				Lan	
E S		The state of the s	THE CONTRIBUTION	- continuating to	Gestii i	out not i	eauting (in tha un	loariying	cause	given in	Part I.		PERFOR		246	AWAILABLE PRIOR TO COMPLETION OF CAUSE
shows any : MEDIC	,													YES 2		17.7	OF DEATH?
S = 2		DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE C	OF DEA	TH YE	S 🗆 N	10 C	UNC	ERTAIN	N K		SPE	CTIO	IN	1 YES 2 NO
red, or item 23 shows any in PHYSICIAN: MEDICAL	ł	25. WAS CASE REFERRED TO EXAMINER?					E OF DEAT	H (Check o	only one)				-1				
YSI	1	1 X YES 2 NO		HOSPITAL:	ER/Out	patient 3	□ DOA	4 Num		5 X R	esidence	8 🗆 0	ther (Spe	icfly)			
P e		27. MANNER OF DEATH	Pending	26a. DATE OF (Month, E			26b. TIM INJ	URY	28c, INJ WO			28d. [DESCRIB	E HOW IF	JURY OC	CURED	
marked, BY PH		2 Accident	Investigation	A				М		'ES 2 [NO						
COMPLETED			Could not be determined	28e. PLACE C building,	etc. (Spe	Y — At ho	me, farm, s	treet, facto	ory, office			281. L	OCATION	(Street a	nd Number	or Rural I	Route Number,
BE COMPLE				CIAN: To the beat of													
	L	one) 2XXMEDI	CAL EXAMINE	R: On the beals of a	xeminatio	on and/or I	Investigatio	n, in my o	pinion, d	esth occu	red at the	time, d	ete and	place, and	d due to th	e ceuse(s	a) and menner as stated.
BE		29b, SIGNATURE AND TITLE	OF CERTIFIER	0 00							ENSE NUN						(Month, Day, Year)
P	-	30. NAME AND ADDRESS OF	BEBSON WIT	h Chut	(40)	AT11 ##-	14 am ~	0.4-4		0.	C.M	. E			M	AY	19,1995
		U. HAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	ac OF DE				tree	et.	Bal	tin	nore	e. N	Marv	lan	d 21201
	11	24 DATE EU ED (14	ther 1	No milasani	Casta	MURE								_, .			
	MAY 2 3 1995 Julia Decidoren Marketture																



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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									9	5	15772
FOR STATE REGISTRAR		STATE OF N	TARYLAN			HEALTH AND F DEATH	MENTA	L HYGIEN			
1. DECEDENT'S NAME (Flist, M ROBE		W				ZWERCK	MONTI	OF DEATH	AY	YEAR 991	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 215-09-8705		. \$EX	6. AGE (In y	_	IF UNDER 1 YEAR		7. DATE (Monti	OF BIRTH		S. BIRTHP Country	
9a. FACILITY NAME (If not instit	tution, give street	and number)			96. CITY, TOW	N OR LOCATION OF D	_	19, 1		NTY OF DE	aryland
Northwest		tal Cen	ter	ŀ		Randa1	1stow	m		Balt:	imore
RESIDENCE OF DECE	DENT 0b. COUNTY			10c, CITY	TOWN OR LO	CATION					10d. INSIDE CITY
Maryland	Baltin	nore			Baltin	more Coun	ty				LIMITS?
10e. STREET AND NUMBER 3533 Mea	dorradd	e Roa	1			10f. ZIP CODE			10g. CIT		HAT COUNTRY?
11. MARITAL STATUS		. WAS DECEDEN		SARMED	12 MBC D	21207 ECENDENT OF HISPA	NIC ODICIN	10 Mar - 14 Mar		U.S.A	
1 Never Married 2 A Ma 3 Wildowed 4 Divorce	nrried	FORCES? 1 IF YES, GIVE W	X YES 2	NO	If yes,	specify Cuben, Maxic ES 2 1 NO Speci	an, Puerto I	rr (Specify te Rican, atc.)	s or No	Specify	
15, DECED	ENT'S EOUCATI	ION		a. DECEDENT'S U	SUAL OCCUPA	TION	16b	. KIND OF BU	SINESS/INI		hite
(Specify only his Elementary/Secondary (0-12	ighest grade con	College (1-4 or 5 +	,	Give kind of we life. Do NOT use	retired.)	most of working		Vesti			
17. FATHER'S NAME (First, Midd	fle, Last)			- 1,1507	,,,,	16. MOTHER'S NA					
Unkno	wn		Sommer	rwerck		S	arah	C	latch	ney	
19a. INFORMANT'S NAME (Type	-176					at and Number or Rural		ber, City or Tow	n, State, Zij	Code)	
Mrs. Mildre		erwerck				side Road	Ва	1timo:	re, M	ID 2	207
20a. METHOD OF DISPOSITION 1 → Burlal 2 □ Cremation	3 - Ramoval	from State	20b. PL cemeter	ACEAND DATE OF ry, cremetory or other Dodlawn	DISPOSITION (Neme of	DATI			City or Tow	
4 ☐ Donation 5 ☐ Other (St 21. SIGNATURE OF FUNERAL S		SEE /	- Wo	odlawn		AND ADDRESS OF FA	5/2	2 Wo	odlaw	m, Ma	ryland
1/2	h	1 (/2	1	~		ng Byers		al Di	recto	rs, 1	Inc.
Nepus	m 01	Jen	9 Cy	b	8728	Liberty :	Road	Randa	allst	own,	MD 21133
23. PART I. Enfer the dise ahock, or head	rt fellure. Lief	only one ceu	se Dn each	e deeth. DD no iline.	t enter the n	node of dying, suc	ch aa cerd	liac Dr reap	iratory ar	rest,	Approximate Interval Between
iMMEDIATE CAUSE (Finel disease or condition resulting in death)		REN	AL	FAI	LUR	E WIT	14 (CHF			Onset and Death
AND THE MARKET		DUE TO	OR AS A CO	NSEQUENCE OF):		STEN					
Sequentielly liet condition				ITO IC	110	SIEV	105	6)			-
if any, leading to immedia cause. Enter UNDERLYING	a l			,							i
CAUSE (Disease or Injury thet initieted events	1	DUE TO	OR AS A CO	INSEQUENCE OF):							+
resulting in deeth) LAST	d										
PART II. Other significent	conditions c	ontributing to	deeth but	not resulting in	the underly	ing ceuse given in	Part I.	24a. WAS AN	AUTOPSY	24b. 3	VERE AUTOPSY FINDINGS
BILATERM				FFUSION				PERFO	RMED?		WAILABLE PRIOR TO COMPLETION OF CAUSE
								1 123 4	(DHO	- 1	OF DEATH?
DID TOBACCO USE	CONTRIB	UTE TO CA	USE OF (DEATH YES	□ NO	UNCERTAI	N/Ø				
25. WAS CASE REFERRED TO N EXAMINER?		OSPITAL:	28.	PLACE OF DEATH	(Check only on	е)					
1 YES 2 NO	17	Inpatient 2		mt 3 🗆 DOA 4	☐ Nursing H	ome 5 - Residence					
1 Ratural 5 Per	nding estigation	28e. DATE OF (Month, De		28b. TIME INJUI	44 /	NJURY AT NORK? YES 2 NO	28d. DE\$	CRIBE HOW I	NJURY OC	CURED	
3 Suicide 8 Co	uld not be ermined	28e. PLACE Of building,	INJURY — a	At home, farm, str.	eel, factory, of	fica		ATION (Street or Town, State)		or Rural Ro	ute Number,
						ite and place, and du					and menner as stated.
296. SIGNATURE AND TITLE OF			10			29c. LICENSE NU		7 7			Month, Day/(Year)
30, NAME AND ADDRESS OF PI	ERSON WHO CO	OMPLETED CAUS	E OF DEATH	(ITEM 27) (Type, P	rint)	1 2	12.	77	,	1144	11,73.
C	·KAI	MMD	PY	HC:	SALT	ro. MD	2-11	53			
31. MAY 23 1995	3 Jalo	#2 4w354#A	T'S SIGNATU	AE.							

E Total

	95-130 FilmG,	/24, item :	#10c,1	0e, 10	of, 6/	12/95,	cyw,	per f	h.	95		0110
	1 - STATE REGISTRAR	STATE OF MAI				F HEALT			HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF				3. TIME OF DEATH
	JOSHUA	ARRON	J			SANK		MAY	15		YEAR 95	1:20 F
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last	birthday)	IF UNDER 1 Y	EAR IF UND	ER 24 HRS.	7. DATE OF (Month, L		<u> </u>	B. BIRTH	PLACE (State or Foreign
	218-98-6413	1 ☑ M 2 □ F	13	YRS.	MONTHS D	NYS HOURS	MIN.	(Month, E	Say, Year)	.02	Country	
	9a. FACILITY NAME (If not institution, give s		1.5		Ab CITY TO	WN OR LOCA	TION OF D	Jan 2	5, 15			Virginia
DIRECTOR	PAINTERS MILL R	OAD & RE	D RUN			NGS M					TIM(
EC	10a. STATE 10b. COUNTY	1	7	10c CITY	Y, TOWN OR I	OCATION						404 WAIDS OUT
E	W1 1 D 1:						Dar	ndalls	t or in			10d. INSIDE CITY LIMITS?
	Maryland Balt:	imore Co.		1	Reiste	rstowr	L.	lualis	COWII			1 YES 2 NO
FUNERAL						101. ZIP CO	DE			10g. CITI	ZEN OF W	HAT COUNTRY?
Ü	11908 Tarragon	Rd. 8416 Ho	ration	Roa	d	2.1	136-	21133		US	A	
5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARI	MED	13. WAS			NIC ORIGIN? (14. BACE	- American Indian,
	1 Never Married 2 Married	FORCES? 1		0		s, specify Cui		n, Puerto Ric	en, etc.)		Specific	, White, etc.
ВУ	3 Widowed 4 Divorced				'-		форт	7.			Specif	White
	15. DECEDENT'S EDUI (Specify only highest grade	CATION	18a. DE	CEOENT'S	USUAL OCCL	PATION		16b. K	ND OF BUS	INESS/IND	USTRY	
H	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	vork done duri e retired.)	ng most of wor	ldng		1/0	+K		
립	6th		Sti	ıdent					/ / / -			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		000	adene		18. MC	THER'S NA	ME (First, Mid	dle Maiden	Sumamal		
	Philip T. Sank					111:00						
BE	19a. INFORMANT'S NAME (Type/Print)		101	MARINO	ADDRESS (O			nya Fi Route Number,				
5												
	Mrs. Sonya McCabe	2					. Re	eister	~			1136
	1 🛱 Burial 2 □ Cremation 3 □ Rem	oval Irom State	20b. PLACE A cemetery, cres	natory or of	her place)			OATE	1	CATION -		
	4 Donation 5 Other (Specify)		Lake V	/iew	Memor	ial Pa	rk	15-19	Syk	esvi	11e,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				E AND ADDR		CILITY				
	Tolong /	M. O.)						meral Directors,				
	22 PAST I Enter the diseases of	Agned	de la maria de		1872	3 Libe	rty I	Rd. R	anda]	lsto	wn,	
	23. PART I. Enter the diseases, or o shock, or heart fellure.	complications that ce List only one couse (used the de- on each line.	eth. Do n	ot enter the	mode of d	lying, auc	h an cardle	or respli	retory arr	est,	Approximata Interval Batwe
- 1	IMMEDIATE CAUSE (Finel											Onset and Da
	disease or condition resulting in death)	. HEAD	2 NT	TOK	IN.	JURIE	S					
	Todasking in casking	DUE TO (OR	AS A CONSEC			1 4 4						1
z		b.										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate		AS A CONSEC	UENCE OF	7:							-
¥	cause. Enter UNDERLYING											
Ĭ.	CAUSE (Disease or Injury that Initiated events	OUE TO (OR	AS A CONSEO	UENCE OF):							+
분	resulting in death) LAST											
빙		0										+
7	PART II. Other algnificant condition	e contributing to dee	oth but not re	sulting i	n the unde	iying cause	given in	Part I. 24	in. WAS AN			WERE AUTOPSY FINDIN
3									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
								— ['	YES 2	NO		OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAUS	F OF DEAT	TH YE	SINO		CERTAIL					1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL						CLRIMII	- L				
고 □	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
ΥS	XIX YES 2 NO	1 Inpatient 2 ER					Residence	XX Other (S	pecify) RC	ADW	AY	
PH	27. MANNER OF DEATH	28a. DATE OF INJU		28b. TIME INJU	URY 28	WORK?		28d. DESCR	IBE HOW IN	DURY OCC		AUGO.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

ВУ

COMPLETED

BE

2

29a. CERTIFIER

BALTIMORE, MARYLAND 21215-0020

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO

Approximata Interval Batween **Onset and Death**

27. MANNER OF DEATH 28a. DATE OF INJURY

2 Accident 3 Sulcide 8 Could not be determined 4 Homicide

28b. TIME OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO 1230 28a. PLACE OF INJURY — At home, larm, building, atc. (Specify)

atreat, lactory, office STRUGT

XX Other (Specify) ROADWAY COLUSION 281. LOCATION (Street and Notinger by Files Ports Agount L M)

MILL RIP & RED RUN BLIP dge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

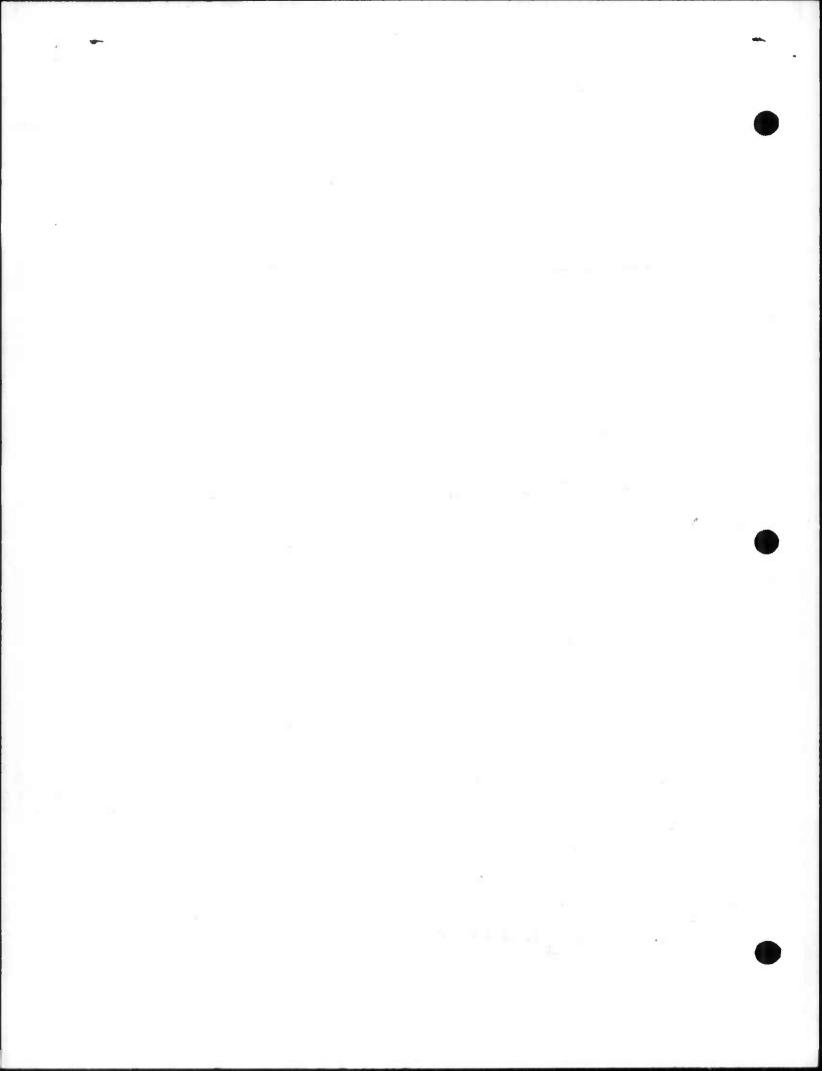
O.C.M.E

29d. DATE SIGNED (Month, Day, Year) MAY 16,1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MP111

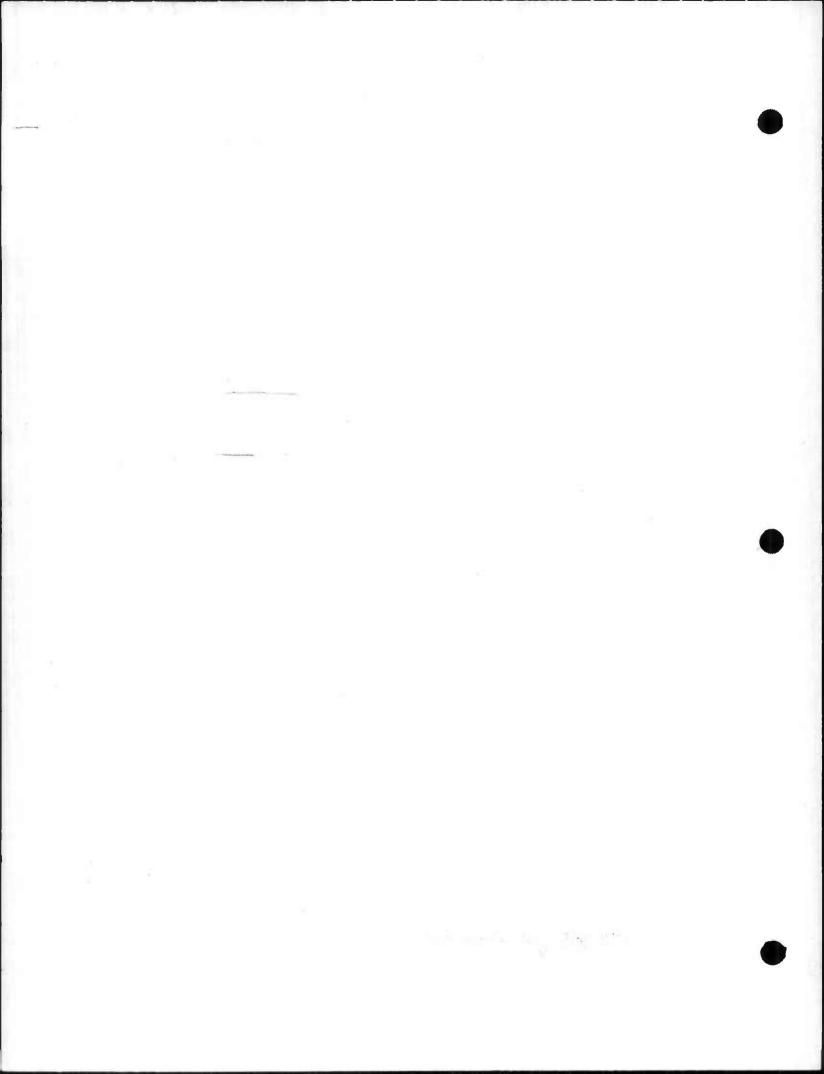
Penn Street, Baltimore, Maryland 21201 32 REGISTRAR'S SIENATURE

31. DATE FILED (Month, Day, Year)
MAY 2 3 1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-		
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fter d	the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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	ITEMS: 3.18.20b,								9	5	15/14
	1 - STATE REGISTRAR	STATE OF MA	ARYLAND . C	/ DEPARTI ERTIFIC	MENT OF CATE OF	HEALTH AND	MENTA	IL HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, L.							OF DEATH		YEAR 3	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	HOMAS		AUNDE				5-20-	95		12:15
	213-16-6221	5. SEX	8. AGE (In yrs. Ia		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8/7/1912			s. BIRTHPL Country)	ACE (State or Foreign
~	9e. FACILITY NAME (If not institution, g			9	b. CITY, TOWN	OR LOCATION OF D				TY OF DEA	
10	2022 W. Sara				Ba1	timore			n/a	a	
DIRECTOR	Md . 10b. CO.	INTY			TOWN OR LOCA					1.0	Od. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				10	Of. ZIP CODE			10g. CITIZ		AT COUNTRY?
FUNERAL	2022 W. Sara	atoga St.				21	223	US			
5	11. MARITAL STATUS	12. WAS DECEDENT I	EVER IN U.S. ARMED 13, WAS DECENDENT OF HISPAI					N? (Specify Y	en or No		- American Indian, White, etc.
ВУ Е	1 Never Married 2 Merried	YES 2 2	INO	If yes, s	pecify Cuban, Mexica S 2 NO Specific	n, Puerto	Rican, etc.)		Black, \ Specify:	White, etc.	
	3 Widowed 4 Divorced				21.				Blac	ck	
TED	15. DECEDENT'S I (Specify only highest g	16a. D	ECEDENT'S US	BUAL OCCUPAT k done during m retired.)	ION lost of working	168	b. KIND OF B	USINESS/INDU	STRY		
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life								
COMPL				Labo	orer		C	const	ructi	on	
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First,	Middle, Maide	n Surname)		
BE	Norman	Sai	ınders			Lil			Y ANN (NN)
2	19a. INFORMANT'S NAME (Type/Print)					end Number or Rural					
		ris	2	2022 V	V. Sai	catoga S	St.	Balt.	o., M	d. 2	21223
	20e. METHOD OF DISPOSITION 1 Description 3	lemoval from State		AND DATE OF I	DISPOSITION (N		DAT		OCATION — C		
	4 🗆 Downthap 8 🗆 Other (Specify) _			butus	5	5/26	5/2	5 Ba	1to.,	Md.	
	21. HUNATURE OF FUNERAL SERVICE	LICENSEE	-			OS A. MO		nc	Conc		
	Jame	o a. 11	1716	M						Ma	. 21217
ICATION	shock, or heert feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CARDIO MARY ARTERY DISEASE) CORO NARY ARTERY DISEASE										Onset and De 30 mm
CERTIFI	that initiated events resulting in death) LAST	DUE TO (0)	R AS A CONSE	EQUENCE OF):							
_	PART II. Other aignificent condit	ions contributing to de	eth but not	resulting in t	the underlyin	ng cause given in	Part i.	24a. WAS A			ERE AUTOPSY FINDING
EDICAL	CONGESTIVE							t TYES	RMED?	C	MILABLE PRIOR TO OMPLETION OF CAUSE
ME	CHRONIC C	BSTRACT	VE PI	UL MO	NARY	DISEAS	E-				DEATH?
	DID TOBACCO USE CON										
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one)						
)S	1 VES 2 NO	HOSPITAL:	R/Outpetient 3		THER:	ne 5 Mesidence	8 🗆 Othe	er (Specify)			
PHY	27. MANNER OF DEATH	28e. DATE OF IN		28b. TIME O	F 28c. IN	JURY AT			INJURY OCCU	JRED	
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	100/)	INJUR		ORK? YES 2 NO					
28e. PLACE OF INJURY — At home, farm, street, factory, office clip or flown, Street and No. City or flown, Stete)							r Rural Rout	le Number,			
29e. CERTIFIER (Check only one) 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TITLE OF CERTIFIER PITY SICIAN PITY SICIAN 29e. LICENSE NUMBER 29d. DATE SIGNED (Month, De) 27e. LICENSE NUMBER 29d. DATE SIGNED (Month, De) 27e. LICENSE NUMBER 29d. DATE SIGNED (Month, De) 27e. LICENSE NUMBER											
COMPLET	2 MEDICAL EXAM	INER: On the besis of exam									nd menner as stated.
BE	296. SIGNATURE AND TITLE OF CERTI	FIER	PITY	SICIAL		D302		,	29d. DATE	SIGNED (M	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON THOMAS S. M.			M 27) (Type, Pri		HOSPIT	74	en			
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAN'S	_		460	12001-11	160	ッパ	-1/M	TRE	, 140.
	MAY 23 1995	Jahr Dawel	ion hands	4							
		-									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ETHEL K. SETDMAN 12 +8P. 7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTHPLACE (State or Foreig 218-03-8030 YRS. Mar 20,1919 Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore Northwest Hospital Center Randallstown RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Carroll Westminster permit. 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 513 Spruce Avenue 21157 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ YES 2 ☑ NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married В 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KING OF BUSINESS/INQUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) 12 Claims Examiner Social Security once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles David Kaplan BE Lena Unknown notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Benjamin B. Seidman 513 Spruce Ave., Westminster, MD 21157 2 2 Page 6 may 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Greater Balto. Lodge 5/21/95 4 ☐ Donation 6 ☐ Other (Specify) _ Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. Sol Levinson & Bros. completely filled in by the I rial, cremation, or removal. 6010 Reisterstown Rd, Baltimore, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Betw shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) Onset and Death requires that the death certificate be executed within 24 een signed by the attending physician and completely fill, of Health and Mental Hygiene prior to burial, cremation, disease or condition event, resulting in death) PON (MALÍGNANT) NOMA OF THE LUNG traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other that initisted events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 TES 2 NO OF DEATH? Shows 1 YES 2 NO t. of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Z PHYSICIAN: has be HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem certificate t HOSPITAL: 1 TYES 2 NO OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify) 6 27, MANNER OF SEATH 28s. OATE DF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME DF marked, 28d, DESCRIBE HOW INJURY OCCURED this c Natural Accident 5 Pending 1 YES 2 ND After to BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 ETED L DIRECTOR: A 6 Could not be 4 Homicide 28 determined Hemi 25s. CERTIFIER (Check only one)

CERTIFVING PHYSICIAN: To the treat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manufar as stated, one)

MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manufar as stated. COMPL TO THE HOSPITAL OF THE FUNERAL COMPOSITION TO THE FUNERAL COMPOSITION TO THE FORESTANTS IN 18 filion, in my opinion, death occured at the time, date and place, and due to the causeis) and manner as stated 286. SIGNATURE AND TITLE OF CERT BE 5 QUISE OF DEATH (ITEM 27) (Type, Print) NORTHWEST HOSPITAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Le service de la remanda de la

BALTIMORE, MARYLAND 21215-0020	at the death certificate be executed within Thours after death. Page 6 may be retained by the hospital or attending phospital
BALTIA	hours after death. Page
68760	executed within
RDS, P.O. BOX 68760	certificate be
RDS, F	at the death

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the notified to fact the property of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: It them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

		0 700 5	100105							9;)	0110
	ITEM: 17. PER F.H. FI	STATE OF M			TRACK	T OF L	EAITU	AND I	MENTAL HV	SIENE		
	1 - STATE REGISTRAR	SIMIL OF I					DEAT			ILNE i. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEA	ATH DAY	YEAR	3. TIME OF DEATH
1		GRAM	SCHNEID	ER					MAY 21			5:15 A.M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		MONTHS	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRT (Month, Day, Y		8. BIRT	HPLACE (State or Foreign itry)
	215-10-7212	XX M 2 🗆 F	81	YRS.					лигу 10		4.1	RYLAND
œ	9e. FACILITY NAME (If not institution, give st				9b. CIT		OR LOCATIO				OUNTY OF (ARUNDEL
5	MERIDIAN NURSING	CENTER				SEV	ERNA	PARI		F	ININE A	AKUNDEL
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	ry, town	OR LOCAT	TION				77	10d. INSIDE CITY
		NE ARUNDE	L	<u></u>	GLE	N BUI						1 YES 2 NO
BY FUNERAL	10a. STREET AND NUMBER					10	ZIP CODE			10g. C		WHAT COUNTRY?
NE	201 PHELPS AVENU	JE 12. WAS DECEDENT	EVER IN III O. A.	D1150	1.0			060			_	S.A.
5	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1	YES 2 A	NO	13	If yes, sp	ecity Cuban	, Mexice	IIC ORIGIN? (Spec n, Puerto Rican, e		Blac	CE — American Indien, ck, White, atc.
	3 Widowed 4 Divorced	IF TES, GIVE W	AR OR DATES			1 🗌 YES	2X□ NO	Specify	/ :		Spec	white
16. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY								WILLE				
Elementary/Secondary (0-12) College (1-4 or 5+) Illie. Do NOT use retired.) 12 N/A HEAD OF PAINT SHOP COAST GUARD												
JOHN HENRY SCHNEIDER CRAVE VIRGINIA SANFORD								FORD				
٩	GRACE PTACEK								EN BURN			060
	20a. METHOD OF DISPOSITION		20b. PLACE	AND DATE	OF DISPO	SITION (Na				De. LOCATION		
	1 Burial 2 Cremation 3 Remo	wal from State	CI EN			,	T DAI			LEN BU	RNIE.	, MD. 21060
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	CLEN	THE VENE	22	. NAME A	D ADDRES	S OF FA	CILITY	LETON	FIINE	RAL HOME,
	1 8 X	3/4	2-		1	SECO	ND AV	VE				E, MD. 21061
	23. PART I. Enter the diseeses, or c	omplications that	ceused the d	eeth. Do	not enta	r the mo	de of dyln	ng, mucl	h ss cardiac or	respiratory	arrent,	Approximate
	shock, or heart fellure. I IMMEDIATE CAUSE (Finsi											interval Between Onset and Dasth
	disease or condition resulting in death)	AN	(ENUO	50	LER	201	(C) (AN	(D) (O)	15CU	LAK	2420
		DUE TO	OR AS A CONSE	OUENCE O	F):	_			0	Isla	10	
ON	Sequentieily list conditions,	b	OR AS A CONSE									
AT	if any, issding to immediate cause. Enter UNDERLYING	502.10 (On AS A CONSE	OUENCE U	r):							
F	CAUSE (Disesse or Injury that initiated events	DUE TO	OR AS A CONSE	OUENCE O	சு:							
ERTIFICATION	resulting in death) LAST	s										
O	PART II. Other aignificent conditions	e contributing to	deeth but not	resulting	In the u	ndertvin	r ceuse of	lven In	Part i 24a W	AS AN AUTOPS	v 24	b. WERE AUTOPSY FINDINGS
MEDICAL							, ocuse g.		PI	ERFORMED?	- "	AMAILABLE PRIOR TO COMPLETION DF CAUSE
9									_ '''	ES 2 410		DF DEATH?
2	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	ATH YI	ES 🗍	NO F	UNCE	RTAIN	V (1)			1 TES 2 THO
IA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			CE OF DEA								
SIG	1 TES 2 THO	HOSPITAL: 1 Inpatient 2	ER/Outpatient	DOA	OTHE 40-M		e 5 🗆 Res	Idence	6 Other (Specif	y)		
PHYSICIAN:	27. MANNER OF DEATH 1 Antural 5 Pending	28e. DATE OF (Month, Da		26b. TIN	IE OF JURY	28c. INJ WO	URY AT		26d. DESCRIBE	HOW INJURY	CCURED	
BY	1 Natural 5 Pending 2 Accident Investigation				M		rES 2 🗌	NO				
ED	3 Suicide 6 Could not be 4 Homicide datermined	building,	FINJURY — At he atc. (Specify)	ome, ferm,	street, fed	ctory, offic			261. LOCATION (S City or Town,	Street and Numi State)	ber or Rural	Route Number,
<u> </u>	29e. CERTIFIER											
COMPLETE	(Check only one) 2 MEDICAL EXAMINER											was marked her
	29b. SIGNATURE AND TITLE OF CERTIFIER			verigatif	, ni niy	ориноп, о						
BE	ALL A	Λ),	edip				29c. LICEN		T 6	29d. D		O (Month, Day, Year)
2	20 NAME AND ADDRESS OF REPORT WAS							(, 6		700	10-

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BACTIMUME



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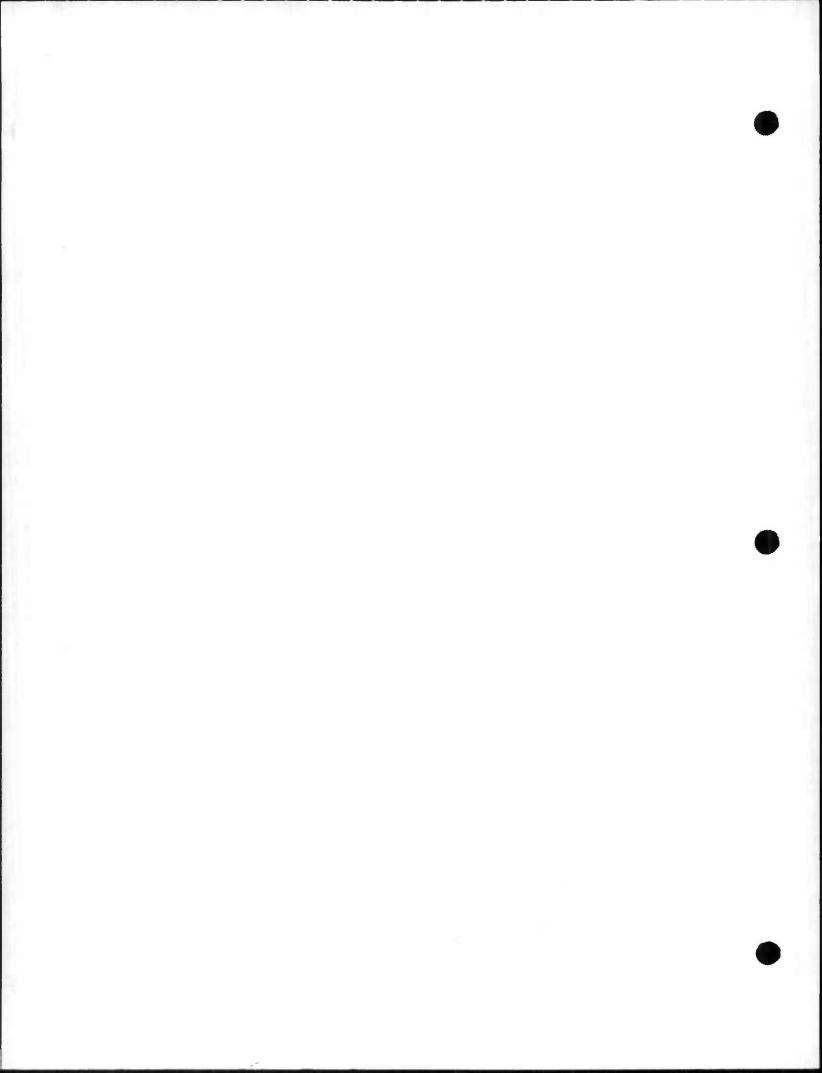
31. DATE FILED (MORD) 20% 1995

MO 20221

020	physic
BALTIMORE, MARYLAND 21215-0020	after death. Page 5 may be retained by the hospital or attending ph
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ND	hospital
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MAR	retained
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) RE	шау
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2	Pag
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X 68760	executed within E
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1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR	CERTIFI	CATE OF DEATH	REG. I	NO.	
		1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
		LOUISE MARY	ADD TOGO		MONTH	DAY YEA	
		TOOTOE	SPRIGGS		MAY 1		1:20 A M
			AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 MONTHS DAYS HOURS	MIN. 7. DATE OF BIRTH (Month, Day, Year	8. B	IRTHPLACE (State or Foreign ountry)
-		216-03-6985 1 M 2 XF	94 YRS.		JAN. 1.	1901 M	ID
should		9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION		9c. COUNTY C	W
60	Œ	4136 The Alemai				1/	10
2,	일	4136 The Alameda		Baltimore			I.A.
S.	DIRECTOR	10a. STATE 10b. COUNTY	18c. CITY	TOWN OR LOCATION			10d. INSIDE CITY
Pages	E I	MD N/A					LIMITS?
量			Balt	imore			TX YES 2 NO
permit.	FUNERAL	10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
150	1 1 1	4136 The Alameda		21218		77.0.4	
DZO physician. burial-transit	ള	11. MARITAL STATUS 12. WAS DECEDENT EV	FR IN U.S. ARMED		NISPANIC ORIGIN? (Specify	I USA	RACE — American Indian,
Z1Z15-00Z0 Lor attending physic or use as the burial	표	1 Never Married 2 Married FORCES? 1	YES 2X NO	If yes, specify Cuban,	Mexican, Puarto Rican, etc.)	14. F	Black, White, etc.
	₩	3 Wildowed 4 Divorced IF YES, GIVE WAR (OR DATES	t 🗌 YES 2 💢 NO	Specify:	S	Specify:
as th							Black
NSe age	윤	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S U	JSUAL OCCUPATION ork done during most of working	16b. KIND OF	BUSINESS/INDUSTR	TY .
To la	[4]	Elementary/Secondary (8-12) College (1-4 or 5+)	Ille. Do NOT use	retired.)			
3 g 8	립	6th	COOK/ H	OHCERREPED	DDTVA	ו דוא איז יוייי	r V
the hospital or attending detached for use as the once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)	L GOOK/ RI	OUSEKEEPER		TE FAMI	L. I.
	8			16. MOTHE	R'S NAME (First, Middle, Mail	den Sumame)	
ed by t	끪	Joseph Montgomery		Mary	Liza (MAIDE	N NAME- 1	UNKNOWN)
retained 5 should notified		19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street and Number or	Rural Route Number, City or	Town, State, Zip Code)
2 - 10 =	임	Jenny Wilson	/126 m	L . A1 1 . D	7	04040	
Page page		20a. METHOD OF DISPOSITION		he Alameda Ba		21218	
bours after death. Page 6 may be bot in by the funeral director, page or removal. medical examiner must be a			20b. PLACE AND DATE Of			LOCATION — City o	
Age 6 ms director,		4 Donation Other (Specify)	Mt Zion Cen	netery	5-15 Bal	Ltimore,	MD.
AL I IN death. Pag tuneral di i. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS			
death. Pa funeral of				JOSEPH H. B	ROWN JR FUN	ERAL HOM	E. P. A.
DA The fu		10					RE. MD.21223
ours after d in by the or removal		23. PART I. Enter the diseases, or complications that ca	used the death. Do no	ot enter the mode of dving	such as cardiac or re	apiratory arrest	Approximate
filled in on, or re		ahock, or haert failure. List only one ceuse	on each line.		,,	opinatory street,	intarval Between
Tilled in the	1	IMMEDIATE CAUSE (Final	0				Onset and Death
		disease or condition resulting in death)	al Osta	vissele	BRUN		12 400
completely fille ial, cremation,			AS A CONSEQUENCE OF				1
\$ 5 - 8	_						
CA 00 be be execute sician and c rior to buria traumatic	CERTIFICATION	Sequentially list conditions, b.	AS A CONSEQUENCE OF				
be es sian a sor to	Ē	it any, laeding to immediate	AS A CONSECUENCE OF	1.			
ficate be ophysician ne prior to	2	CAUSE (Disease or injury					
certificate ding physichygiene pri	드	that initiated events DUE TO (OR	AS A CONSEQUENCE OF));			
	듄	resulting in death) LAST					
the atten Mental H	빙	6.					
the dear of Menta	1 1	PART II. Other algorificant conditions contributing to dea	ith but not resulting in	the undarlying cause giv	en in Part I. 24s. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
F - 5 -	MEDICAL					FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	٥				1 _ YES	2 200	OF DEATH?
requires seen sign of Heat	8			\ /		/	1 YES 2 NO
		DID TOBACCO USE CONTRIBUTE TO CAUS	E OF DEATH YES	S I NO DELINCE	RTAIN 🗆		
has be Dept.	CIAN:	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH				
N: The licate ha State D	77 1						
	임	EXAMINER? HOSPITAL:		OTHER: \			
IAN:	S	museumme. A			dence 6 Other (Specify)		
SICIAN: certifica the St	HYSI	EXAMINER? 1 VES 2 NO 1 Inpetiant 2 ER. 27. MANNER OF DEATH 28a. DATE OF INJU	/Outpetlent 3 DOA	4 Nursing Home 5 Rask		W INJURY OCCURE	D
The state of	PHYSI	EXAMINER? 1	/Outpetlent 3 DOA	4 Nursing Home 5 Rask OF 26c, INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCURE	0
The state of	HYSI	EXAMINER? 1 YES 2 NO 1 Inpatiant 2 ER 27. MANNER OF DEATH Natural 5 Pending Investigation	URY 28b. TIME INJU	4 Nursing Home 5 Resk OF 26c. INJURY AT WORK? M 1 YES 2 1	28d. DESCRIBE HO		
F st f	D BY PHYSI	EXAMINER? 1 YES 2 NO 1 Inpatiant 2 ER 27. MANNER OF DEATH Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be	/Outpetient 3 DOA URY bear) 28b. TIME INJU JURY — At home, farm, st	4 Nursing Home 5 Resk OF 26c. INJURY AT WORK? M 1 YES 2 1	28d. DESCRIBE HO	et and Number or Ru	
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AL OR ATTENDING PHYS AL DIRECTOR: After this 72 hours after death with 1f item 28 is marked	MPLETED BY PHYSI	EXAMINER? t YES 2 NO 1 Inpatiant 2 ER. 27. MANNER OF DEATH 28a. DATE OF INJ. (Month, Day, Y. 1) Natural 5 Pending Investigation 26a. PLACE OF IN. building, atc. 29a. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my Investigation 1 CERTIFYING PNYSICIAN: To the best of my Investigation 1	URY 28b. TIME INJU JURY At home, farm, st (Specify)	4 Nursing Home 5 Reads CF 26c. INJURY AT WORK? 1 YES 2 1	28d. DESCRIBE HO 28f. LOCATION (Sin City or Town, Si	net and Number or Ru are)	irel Route Number,
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OR ATTENDING PHYS DIRECTOR: After this hours after death with	BE COMPLETED BY PHYSI	EXAMINER? t YES 2 NO 1 Inpatiant 2 ER. 27. MANNER OF DEATH 28a. DATE OF INJ. (Month, Day, M. 1) 2 Accident 3 Suicide 6 Could not be detarmined 26a. PLACE OF IN. building, atc. 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination of the basis of examin	URY 28b. TIME INJU JURY At home, farm, st (Specify) knowledge, death occurred nation and/or investigation	4 Nursing Home 5 Rask OF 26c. INJURY AT WORK? M 1 YES 2 I reet, factory, office d at the time, date and placa, at i, in my opinion, death occured	28d. DESCRIBE HO 28f. LOCATION (Similar City or Town, St and due to the cause(s) and at the time, data and place	eet and Number or Ru ate) manner as atated.	ee(s) and menner as stated.
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AL OR ATTENDING PHYS AL DIRECTOR: After this 72 hours after death with 1f item 28 is marked	BE COMPLETED BY PHYSI	EXAMINER? t YES 2 NO 1 Inpatiant 2 ER. 27. MANNER OF DEATH 28a. DATE OF INJ. (Month, Day, M. 1) 2 Accident 3 Suicide 6 Could not be detarmined 26a. PLACE OF IN. building, atc. 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination of the basis of examin	URY 28b. TIME INJU JURY At home, farm, st (Specify) knowledge, death occurred nation and/or investigation	4 Nursing Home 5 Rask OF 26c. INJURY AT WORK? M 1 YES 2 I reet, factory, office d at the time, date and placa, at i, in my opinion, death occured	28d. DESCRIBE HO 28f. LOCATION (Sire City or Fown, St and due to the cause(s) and at the time, data and place SE NUMBER 2225	manner as stated. , and due to the cau	ee(s) and menner as stated.
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AL OR ATTENDING PHYS AL DIRECTOR: After this 72 hours after death with 1f item 28 is marked	BE COMPLETED BY PHYSI	EXAMINER? t YES 2 NO 1 Inpatiant 2 ER. 27. MANNER OF DEATH 28a. DATE OF INJ. (Month, Day, M. 1) 2 Accident 3 Suicide 6 Could not be detarmined 26a. PLACE OF IN. building, atc. 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination of the basis of examin	URY 28b. TIME INJU JURY At home, farm, st (Specify) knowledge, death occurred nation and/or investigation	4 Nursing Home 5 Rask OF 26c. INJURY AT WORK? M 1 YES 2 I reet, factory, office d at the time, date and placa, at i, in my opinion, death occured	28d. DESCRIBE HO 28f. LOCATION (Sire City or Fown, St and due to the cause(s) and at the time, data and place SE NUMBER 2225	manner as stated. , and due to the cau	ee(s) and menner as stated.



95-200

ITEM: 7. PER STATE ANATOMY BOARD FILM G-726 B/31/95 t.t 23 PART I, 27, 2Ba-f, PER MEO FILM G-724 6/5/95 t.t

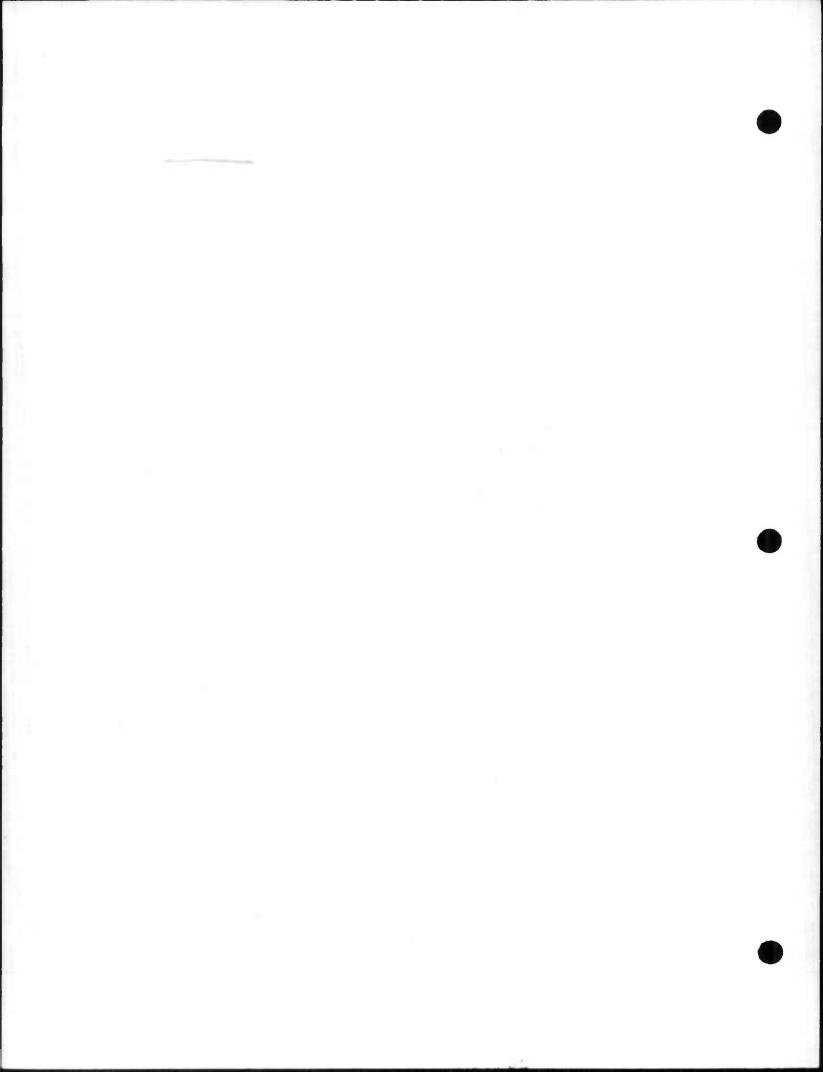
95 15778

ITEMS:

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

i	1. DECEDENT'S NAME (First, Middle, Li	nst)							2. DATE OF	DEATH	AY	YEAR	3. TIME OF DEATN
	JOANN		STRON	IG .					MAY	0.3		95	6:30
	4. SOCIAL SECURITY NUMBER	5. SEX 1 M 2 K F	6. AGE (In yrs	39 yrs.	IF UNDER 1	DAYS	HOURS M		SEPI	BIRTH 16;	1956	T	TNPLACE (State or Fore
OR	9a. FACILITY NAME (If not institution, gr 3204 CLIFTON	AVE					MORE (_	JNTY OF	DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COU			10c. CIT	Y, TOWN OF	R LOCAT	TION						10d, INSIDE CITY
	Maryland			Ва	ltimo	re							1 YES 2 N
FUNERAL	1611 N. Fulton	Avenue				101	H. ZIP CODE				10g. CIT	TIZEN OF	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		TENT EVER IN U.S. 1 YES 2 WAR OR DATES		11	yes, sp	CENDENT OF H pecify Cuben, M S 2 NO S	exican,			or No-	Ble	CE — American Indian. ick, White, atc. scily: black
COMPLETED	15. DECEDENT'S (Specify only highest gi	rade completed) College (1-4 or 5		. DECEDENT'S (Give kind of life. Do NOT u	work done du	CUPATIO	ON ost of working		16b, KI	ND OF BUS	SINESS/INI	DUSTRY	
ш	17. FATHER'S NAME (First, Middle, Last)						18. MOTNER	SNAME	(First, Midd	dle, Maiden	Sumame)		
10 8	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS ((Street a	and Number or F	ural Roo	ite Number,	City or Town	n, State, Zij	ip Code)	
	20e. METNOD OF DISPOSITION 1 Burial 2 Cremetion 3 S			CE AND DATE		FION (Na	ame of		DATE	20c. LO	CATION —	- City or	Town, State
	4 Donation 6 Other (Specify)		ald Wad	e Dir	22 N	AME AN	ND ADDRESS (E EACH	ITV CI	tato	Anat	OMI	Roard
	23. PART I. Enter the diseases, shock, or heart feliu IMMEDIATE CAUSE (Final disease or condition resulting in death)	NARCOT	IC INTOX	ICATION	not enter t								Approximate interval Bate Onset and E
ERTIFICATION	23. PART I. Enter the diseases, shock, or heart fellu iMMEDIATE CAUSE (Final disease or condition	a. NARCOT DUE TO DUE TO C.	use on each i	ICATION ISEQUENCE O	not enter the								Approximate Interval Bate
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O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Places 1, 2, 3 show	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HO	THE FU	be filed wit	IMPORTA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY URKOW 995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year HOURS MIN. 219-07-1258 77 1 XM 2 F YRS. APRIL 2,1918 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH C. COUNTY OF DEATH DIRECTOR BALTIMORE CHERRYWOOD MANOR NURSING HOME REISTERSTOWN RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21215 6930 REISTERSTOWN ROAD U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married В Specify: WHITE 3√Widowed 4 ☐ Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 a) 2 SALESMAN RETAIL 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) SAMUEL TURKOW LILLIAN SHERBOW BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 6006 CAMELBACK LA., COLUMBIA, MD. 21045 MR. EDWARD TURKOW complexy, crematory or other place ANSHE EMUNAH—AITZ CHAIM CONG. BALTIMORE, MD 20a. METHOD OF DISPOSITION

1X Burial 2 Cremation 3 Removal from State 8 Other (Specify) ☐ Donation BALTIMORE, MD. 21. SIGNATURÉ DE FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215 23. PART i. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, ahock, or heart failure. Liet only one ceuse on each line. interval Batween **IMMEDIATE CAUSE (Final** Onset and Death disease or condition en brownila reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not recuiting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 NO OF DEATH? DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TO UNCERTAIN ٤ 1 YES 2 40 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) OTHER:
4 Intersing Home 5 - Residence 8 - Other (Specify) HOSPITAL: 1 YES LENO 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, streat, factory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER

1 DESTRIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) end manner as stated. 2 ___ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(s) and manner es stated.

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 17

un A.

55

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Judil

nkone 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) 3 1995 Muderke

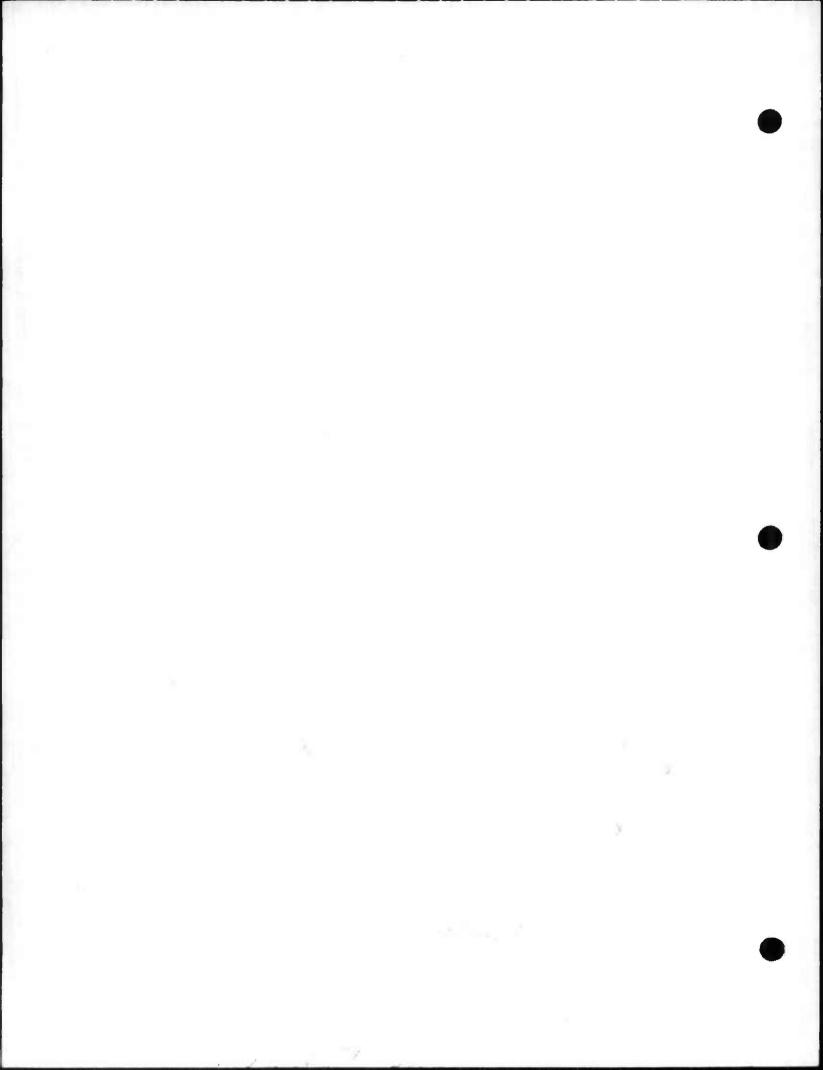
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TO THE HIGSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be essouled wittin 24 hours also death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be dealed attention of numeral director, page 5 should be detached for use as the beds attention of numeral	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.
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2	23	4

1 - STATE REGISTRAR	STATE OF MARYLAN		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	E ^(F)	
4. SOCIAL SECURITY NUMBER	SEX TOP	Vant billinday) IF UND	SER 1 YEAR IF UNDER 24 HRS.	2. DATE OF DEATH DATE OF DEATH	1990	RTHPLACE (Staff or Foliage)
218 42 6418 Bu. FACILITY NAME (If not insolution, give	1 1 1 2 A 7	YRS. MONTH			and the second	Maryland
		36.0	Baltimore	DEATH	Bal:	timore Go.
10s. STATE 10s. COUN	Baltimore	19c. CTTY, TOWN	Baltimore		1	10d. INSIDE CITY LIMITET 1 YES 2 AND
6302 Golden Ring	Rd.		10f. ZIP CODE 21237	,		WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EYER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	25NO	2. WAS DECENDENT OF HISPA If yes, specify Cuban, Musch † YES 2 2 NO Spec	ANIC ORIGIN? (Specify Yes cen, Puerto Rican, etc.)	or No 14. R.	ACE — American Indian, lack, white, etc. nectly: White
15. DECEDENT'S EL (Specify only highest pre Elementary Deconstary (0-12) 17. FATHEN'S NAME (First, Middle, Light Fluction). Mid-		DECEDENT'S USUAL IGNO Aind of work don the Do NOT use recipe Housew	ne during most of working	16b. KIND OF BUE HOT		Y
17. FATHER'S NAME (FIRST, MISSIM, LIGHT) HUCSON MC	Cubbin		18. MOTHER'S A	AME (First, Middle, Marcher)	Sumame)	
Charles J. Truen	an, 3rd	1102 2C	Tace Drive			221
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions.	r complications that caused the b. List only one cause on each	death. Do not entille.	2. NAME AND ADDRESS OF P Bruzdzinski 1407 Eastern or the mode of dyling, su	Funeral Hon	4 marea	MD 21221 Approximate Interval Betwee Onset and De
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	G. OUE TO (OR AS A COR	ISEQUENCE OF):				
PART II. Other significant condition	ons contributing to death but n	ot resulting in the	underlying cause given in	Part I. 24s. WAS AH PERFORM 1 1 YES 2	MED7	ABALABLE PROOF TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO
25, WAS CASE REFERRED TO MEDICAL EXAMINER?		1,000	28. PLACE OF DEATH (C	heck only one)		
25, WAS CASE REFERRED TO MEDICAL EXAMPLE TO NO 27. MANNEY OF DEATH	HOSPITAL: 1 Impatient 2 ER/Outpetien 25e. DATE OF INJURY	26b. TIME OF	ER: ursing Home 5 Residence 25c. INJURY AT	6 ☐ Other (Specify) 28d. DESCRIBE HOW IN	MINA OCCURED	
2 Accident Investigation	25e PLACE OF INJURY - A	INJURY M	WORK7 1 YES 2 NO	281, LOCATION (Street A	7.3141.75.7637.144	
4 Homicide Scanning	ounding, etc. (Specify)	amatembe imagamodan	NO-2000-C	City or Rawn, State)		in reason reasons.
	SICIAN: To the best of my knowledge IER: On the basis of examination and					e(A) and menner as stated.
AGAS OF CERTIFIC	DOTTI MANY	DEVINU	28c LICENSE M			ED (Morath, Day, News)
30. NAME AND ROOMESS OF PERSON W	1 10 March Anary Sanatur	IT Judg	che ?	nsl.		11.70

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	DING	After	death
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_	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN		
	1. DECEOENT'S NAME (First, Middle, Lest)	BETTY	JEAN TAY	LOR		2. DATE OF DEATH MONTH	MY 1	3. TIME OF DEATH
	220-24-8438	1 □ M 2 🛒 F	n yrs. lest birthday) 5 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 13,	8.	BIRTHPLACE (State or Foreign Country) West Virginia
TOR	9a. FACILITY NAME (If not institution, give stre 7577 Beach Drive			Pasade		EATH		Y OF DEATH Arundel
DIRECTOR	10a. STATE 10b. COUNTY Maryland Anne	Arundel		, town on Locat asadena	ON		4	10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 574 Sixth St			101.	ZIP CODE	1122	10g. CITIZEI USA	N OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, spe		NIC ORIGIN? (Specify Ye in, Puerto Rican, etc.) y:	e or No — 14	N. RACE — American Indian, Black, White, etc. Specify: White
PLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)		(Give kind of w life. Do NOT us	usual occupation ork done during mose retired.)	N t of working	16b. KINO OF BU		
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Dave		Bearden			ME (First, Middle, Meider		
TO B	198. INFORMANT'S NAME (Type/Print) Mr. Davis Decke	er	19b. MAILIND 451	ADORESS (Street of Bigley A	Ve., Ba	Acute Number, City or Tow altimore,	vn, State, Zip Co Md • 2	nde) 1227
מאוווו אווווווווווווווווווווווווווווווו	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 X Remov 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUMERIAL SERVICE LICE	ther (Specify) South Bend, Indiana Size Commetery, cremetery or other place) South Bend, Indiana						
196. INFORMANT'S NAME (TyperPrint) Nr. Davis Decker 206. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. BIGNATURE OF FUNERAL SERVICE LICENSEE REVIDED TO (OR AS A CONSEQUENCE OF): 22. MARCA AD ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Bigley Ave., Baltimore, Md. 21227 206. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State 207. PLACE AND DATE OF DISPOSITION (Name of certifiery, cremetory or other place) SOUth lawn Cemetery. 5/20/95 South Bend, I 21. BIGNATURE OF FUNERAL SERVICE LICENSEE REVIDED TO (OR AS A CONSEQUENCE OF): 22. NAME AND ADDRESS OF FACILITY MCCULly Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardiac or raspiratory arrest, 10. MILLIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208. LDCATION — City or Town 209.					Approximata Interval Batweer Onest and Deat Immedia Immedia			
MEDICAL CE	PART II. Other significant conditions	contributing to deeth bu	ut not resulting i	n the underlying	ceuse given in	Part I. 24e. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:		HOSPITAL:	28. PLACE OF DEAT		UNCERTAIN	N 🔲		
BY PHYS	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY WOR	RY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUP	REO
9	3 Suictde 8 Could not be 4 Homicide determined	28e, PLACE OF INJURY building, etc. (Speci	— At home, term, s	treet, factory, office		281. LOCATION (Street City or Town, State		Rural Route Number,
티시		AN: To the best of my knowle On the best of examination						euse(e) and manner ee stated.
TO BE COM	30. NAME AND ADDRESS OF PERSON WHO		TH (ITEM 27) (Type,	Print)	29c. LICENSE NUN	211	15	IGNED (Month, Day, Year)
	Dr. Ira Ka 31. DATE FILED (Month, Day, Year) MAY 2 3 1995 Full	plan, M.D.		wood Rd.	, Glen	Burnie, Ma	rytano	21061



		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIE		
	1		ATORE	VALE	NZIANO		2. DATE OF DEATH MONTH May 16		3. TIME OF DEATH 9:53 pm M
pin		4. SOCIAL SECURITY NUMBER 216-42-5438	1 X M 2 D F	73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 2, 1	8.	BIRTHPLACE (State or Foreign Country) TALY SICILY
1, 2. 3 should	СТОВ	9a. FACILITY NAME (If not institution, give Saint Joseph Med RESIDENCE OF DECEDENT				on Location of D		Balt	OF DEATH
Pages	DIRE	MARYLAND BALT	IMORE		Y, TOWN OR LOCAL OCKEYSV				10d. INSIDE CITY LIMITS? 1 YES 2 NO
in. ransit permit.	VERAL	106. STREET AND NUMBER 10128 Davent	ry Drive		10	7. ZIP CODE 21030			N OF WHAT COUNTRY?
215-0020 attending physician. Ise as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DA	2 ()NO ATES	If yes, sp	CENDENT OF NISPAL Decify Cuban, Mexica 3 2 XO Specifi	NIC ORIGIN? (Specify Y an, Puerto Rican, etc.) fy:	es or No- 14	. RACE American Indian, Black, White, atc. Specify: WHITE
21 for c	PLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+) n/a	life. Do NOT us	vork done during me e retired.)	ON ost of working		USINESS/INDUS	TRY
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	COMPL	n/a 17. FATHER'S NAME (First, Middle, Last)		Pres	ser	OUT TO SERVICE	AME (First, Middle, Maide		
MARY retained b 5 should t	TO BE	Giuseppe Val				and Number or Rural	ria DiMarc Route Number, City or To	wn, State, Zip Co	
L S S S		Angela M. Valena	20b	PLACE AND DATE (DEDISPOSITION /N/	ame of	Cockeysvi	11e, Ma	
ALTIMO Jeath, Page 6 funeral direct xaminer mu		20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 1 4 Donation (Xother (Specify)) 21. SIGNATURE OF THE STATE BY AN W	Cerci Clary	atery, cremetory or or of laney Va	Lemmon	nd Adoress of FA	L Home of		y Valley, Inc.
d within 24 hours after ompletely filled in by the 1, cremation, or removal.		23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. ANOXIC ENC	ach line.	ATHY	radon1a	Rd., Timo	DILUM, I	Approximata Interval Between Onset and Death 1 DAY
certificate be executed nding physician and con Hygiene prior to burial, or other traumatic or	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. CEREBROVA DUE TO (OR AS A		ACCIDENT				
requires that the death seen signed by the attent of Health and Mental H shows any Injury, or	MEDICAL CE	PART II. Other significant condition ASPIRATION PNE	UMONIA, CONG	ESTIVE H	EART FAL	URE	Armed	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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11		90. NAME AND ADDRESS OF PERSON W	D., ST. JOSEPH	H MEDICA		FR, 7620 YC	ORK ROAD,	rowson	, MD. 21 204
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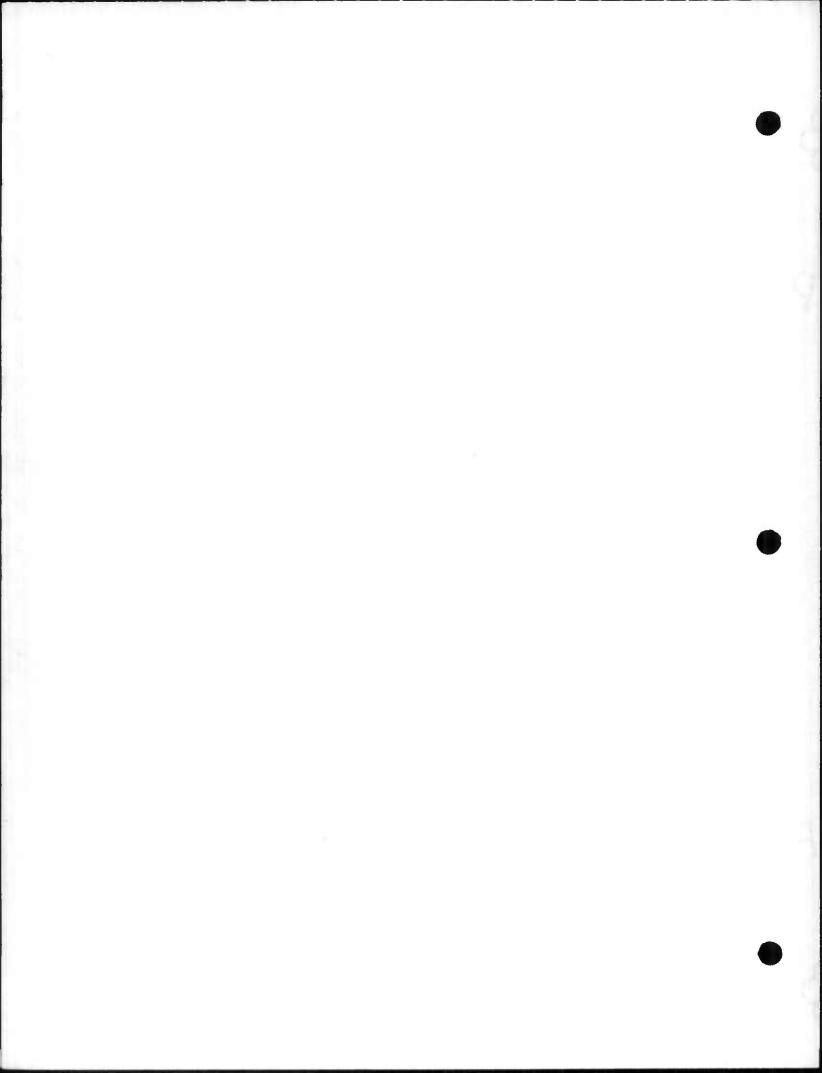
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	DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p be filled within 72 hours after death with the State Deat, of Health and Mental Hydrene prior to burial, cremation, or removal.	
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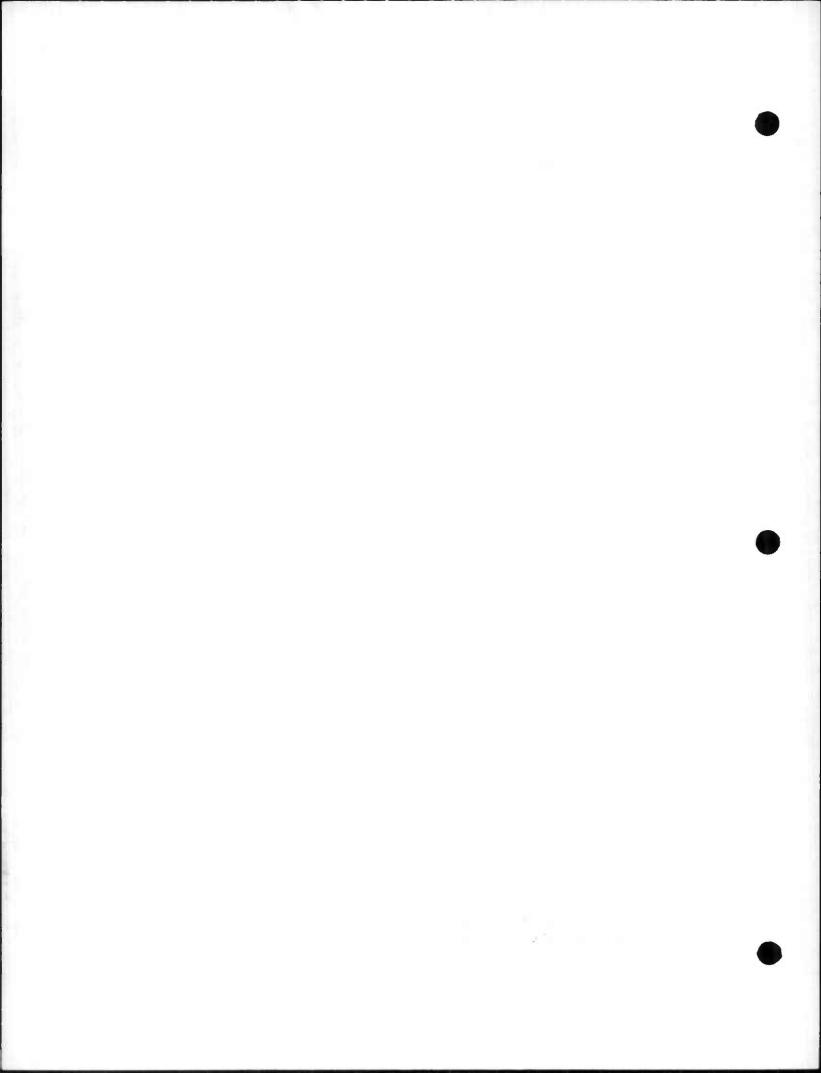
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH MAY ELSIE MAE VARINA 19. 1995 3:15 Рм 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 🗌 M 2 🙀 F DAYS HOURS YRS. 220-03-5628 11- 21- 1921 MARYLAND permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 928 LANGLEY ROAD 21060 U.S.A. funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES X 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried If yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: WHITE 16e. DECEOENT'S USUAL OCCUPATION COMPLETED 15. OECEDENT'S EDUCATION secify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 N/A HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) to DANIEL CARRICK **EMMA** BE HILL notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CHARLES W. VARINA 928 LANGLEY ROAD, GLEN BURNIE, MARYLAND 21060 Pe 20e. METHOD OF DISPOSITION
1X Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 1X Burlet 2 Gremanum
4*Donetion 5 Other (Specify) GLEN BURNIE, MARYLAND MORIAL PARK 1995

22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W. 1995 21. SIGNATURE OF PUNERAL SERVICE LICENSEE the medical examiner in and completely filled in by the to burial, cremation, or removal GLEN BURNIE. MD. 21061 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line. interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death disease or condition certificate be executed within 24 Preumonia event, resulting in death) 2WL DUE TO (OR AS A CONSEQUENCE OF): Ischemic bowel traumatic CERTIFICATION 1 wh attending physician and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate prior e. Enter UNDERLYING Free by VIII wihihi nihibitor CAUSE (Disease or Injury 2 mo that initiated events resulting in death) LAST 0 the atter PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY PERFORMED? been signed by the that shows any 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{Z}}}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate I HOSPITAL: OTHER: 1 YES 2 300 ATTENDING PHYSICIAN: 1 Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, with this 1 Natural 5 Pending М 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 8 Could not be COMPLETED 4 Homicide 28 Tem 9 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. TO THE HOSPITAL (TO THE FUNERAL C DE filed within 72 h (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as attend. 29b. SKINAPURE AND JITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 21404 SA 1111 ResiDent 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. O IDONNEU SK. REDIDENT JUINS HOPKINS HUSDIAM MD

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	be fined within 1.2 founds after death with the State Usp. Or feating and whether the features of the features are the features of the features and features are the features of the features
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95 15785 ITEM: 1. PER F.H. FILM G-723 5/23/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN MAY lizabeth 7:25 agner ELIZABETH MARGARET WAGNER PM 18 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFITH (Month, Day, Year) Feb. 21, 8. BIRTNPLACE (State or Foreign Country) DAYS HOURS 1 M 2 X F 83 217-34-9376 Maryland 1912 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Church Hospital Baltimore N/A RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore. 1 - YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 13117 Miles Road 21220 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No--it yes, specify Cuben, Maxican, Puarto Rican, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 🛚 Widowed 4 🗌 Divorced Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Secondary (0-12) College (1-4 or 5 +) N/A N/A Sales Person Retail Store 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Joseph Weidel Rose Nolan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Betty M. Shamleffer (Dghtr) 13117 Miles Road, Baltimore, Md. 20g METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State Most Holy Redeemer Cem. 4 Donation 5 Other (Specify) 5/22/95 Baltimore. Maruland 22. NAME AND ADDRESS OF FACILITY
Schimunek Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 3331 Brehms Lane, Baltimore, Md. 21213 23. PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Sepsis resulting in death) DUE TO (OR AS A CONSEQUENCE OF) oronary Artery Disease Unknown CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING erebrovascular CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Diabetes Mellitus 1 YES 2 1 NO OF DEATH? Hypertension 1 YES 2 NO DID TOBÁCCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: **EXAMINER?** 1 YES 2 NO OTHER: Inpatient 2 ER/Outpatient 3 DOA ng Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER DY1365 29d. DATE SIGNED (Month, Day, Year) May 18, 1995 IL M

ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

GROVER E. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE AAY 23 1995

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DIVISION OF VITAL RECORDS,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	eath with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.
	marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
asth with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	Wer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, 3 should
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Wer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should

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23. PARTY Enter the dispesses, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or shart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) A consequence of pick as a cardiac or respiratory arrest, shock, or shart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) A consequence of pick as a consequence of pic				pisPosition (Name of	DATE 20c LOCATION +	- City or Town, State								
23. PART II. Other algoritions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24. WAS AN AUTOPS' PERFORMEDT COMPLETED CAUSE OF DEATH (TIES 2) NO STAFF 1 Subscides of DEATH 1 Secused investigation. 25. PART II. Other algoritions contributing to deeth but not resulting in the underlying ceuse given in Part II. 26. PLACE OF DEATH (TIES 2) NO STAFF 1 Subscides of Contributing to death Death (Specify) 27. MANNER OF DEATH 1 MOSPITAL. 28. PLACE OF INJUSTY 28. MANNER OF DEATH 1 Secused of Justice Subscides of Contributing to Resultance of Part II. 29. PLACE OF INJUSTY 28. MANNER OF DEATH 1 Secused of Justice Subscides of Contribution of Contribution and Subscides of Contribution of Contributio		4 Donation 5 Other (Specify)	I vvooa	awn	3/26/95 Balt	O. Co. Ma,								
Approximate interval Between One of dying, such as cardiac or raspiratory arrest, whock, or femant failure. List only one cause on each line. MMEDIATE CAUSE (Final disease or conditions of conditions on the cause on each line.		21. SIGNATURE OF FUNERAL BERVICE LIK	SEMBLE P		SUSS FILES	nal Hama								
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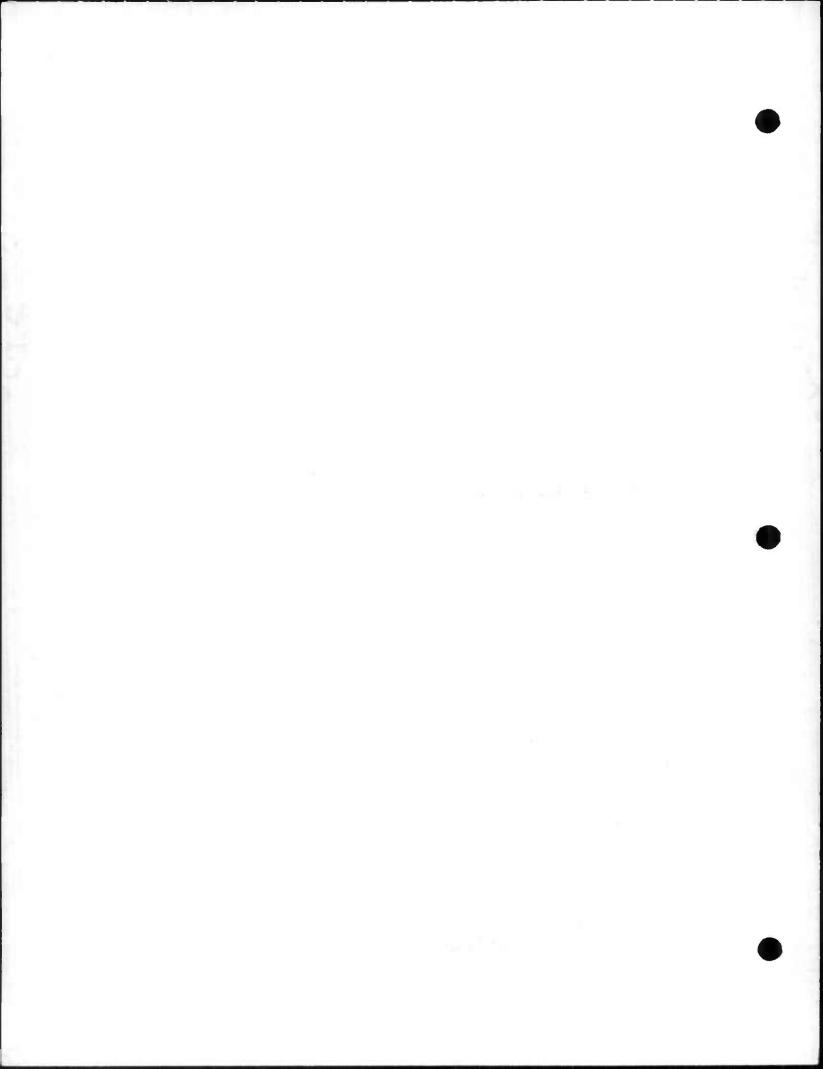
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	- 1		4. SOCIAL SECURITY NUM		5. SEX		(In yrs. las		IF UNDER	DAYS	HOURS 2	4 HRS.	7. DATE OF (Month, D	BIRTH lay, Year)		6. BIRTI	HPLACE (State or Forei	
	2		202-16-37		1 M 2 X F		3	YRS.	ONTINE		Hoons		Sept		192		ennsylva	
2, 3 should		DIRECTOR	9a. FACILITY NAME (If not institution, give street end number) Johns Hopkins Bayview Med. Ctr. Baltimore 9c. COUNTY OF DEATH N/A											DEATH				
,	<i>-</i>	5	RESIDENCE OF DE	10b. COUNT			-	40. 017		20	APPET							
	- and	E	Md.		timore										10d. INSIDE CITY LIMITS? t TYES 2 LNC			
.5			10e. STREET AND NUMBER		cimore			10f, ZIP CODE										
4		FUNERAL	3102 Corn		Road					10	2122	2			U.S.		WHAT COUNTRY?	
5-0020 nding physician.		BY FUN	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Dive	arried 2 Married FORCES? 1 YES				2 NO If yes, specify Cuben, Mexic										
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4 9 3	Once.	COMP	17. FATHER'S NAME (First, A	fiddle, Last)						-	18. MOTHE	R'S NAM	E (First, Midd					
5 2	8 %	ш	AMandus	Brobs	t						Haz							
MAR	notified	00	190. INFORMANT'S NAME (Type/Print)			19t	. MAILING	ADDRES	S (Street e	and Number o	r Runai Ro	oute Number,	City or Tow	n, State, Zig	Code)		
2 2 4	, 21	2	George W	. Wal	ton						11 R						21222	
ALTIMORE death. Page 6 may funeral director, pa	ust be		20s. METHOD OF DISPOSITION 10 Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State															
		A	4 Donation 5 Other (Specify) Garrison Forest Vets. 5-23-95 Owings Mills, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE															
	sxamIn	9	Moran-Ashton Funeral Home, Inc. 3000 E. Baltimore St., Balto., Md. 21															
after On			23. PART I. Enter the d	seeses, or	complications the	t ceuse	d the de	eth. Do r	30	the mo	E B	alt	imor	e St	Ba Ba	alto	Approximate	
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secuted and con	(2)	Z	Sequentially list condit	lone C	b	-											į	
K	rior to buri	ERTIFICATION	If any, leading to Imme	diate	DUE TO	(OR AS	CONSEC	UENCE OF	F):									
Cate by C	0 -	2	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated exapts DUE TO (OR AS A CONSEQUENCE OF):															
death certificate	other	E	that initieted events resulting in death) LAS	т	DUE TO	(OH AS /	CONSEC	UENCE OF	7):									
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99	d Mental injury,	4	PART II. Other algnifice	ent condition	ne contributing to	death b	out not n	suiting i	in the u	nderiyin	g ceuse giv	ven in P	ert I. 24	a. WAS AN		24b	. WERE AUTOPSY FIND	
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	¥ Hea	MEDIC													73,		OF DEATH?	
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AL has	e Dept.	M	25. WAS CASE REFERRED T					E OF DEAT		-								
AN: 1	State r item	Sic	EXAMINER?		HOSPITAL:	ER/Out	patient 3	□ DOA	OTHEI	R: rsing Hom	e 5 🗆 Resi	dence 8	Other (S	Other (Specify)				
PHYSICIAN: The	d, or	PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, E		28b. TIME OF 28c. INJURY AT						28d. DESCRIBE HOW INJURY OCCURED					
Z E	marked	BY	1 Netural 5 2 Accident	Pending investigation	(Month, L	ray, rour)		ms	M		YES 2 🗌	NO						
	D	ED B	3 Suicide 8	Could not be	26e. PLACE C	F INJURY	- At ho	ma, ferm, s	street, tec	tory, offic	•		281. LOCATION (Street and Number or Rural Route Number,				Route Number,	
OR ATTENDING	28 afte		4 Homicide	determined		oral Jops	,,						City of a	own, Stete)				
5 8 8		COMPLET	29a. CERTIFIER CERT	TIFYING PHYS	ICIAN: To the best of	my know	ledge, de	th occurre	d at the 1	time, date	end place. =	ind due to	the couse!	e) end mer	ner as stat	ed.		
HOSPITAL	within 72 ITANT: If	MO) and manner ee state	
HOS	be filed within		29b. STORATURE AND TITLE		-	-		_			29c. LICEN						(Month, Day, Year)	
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HO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

W JOHNS HOPKING BANTEW MEDICAL CENTER

12. REGISTRAR'S SIGNATURE



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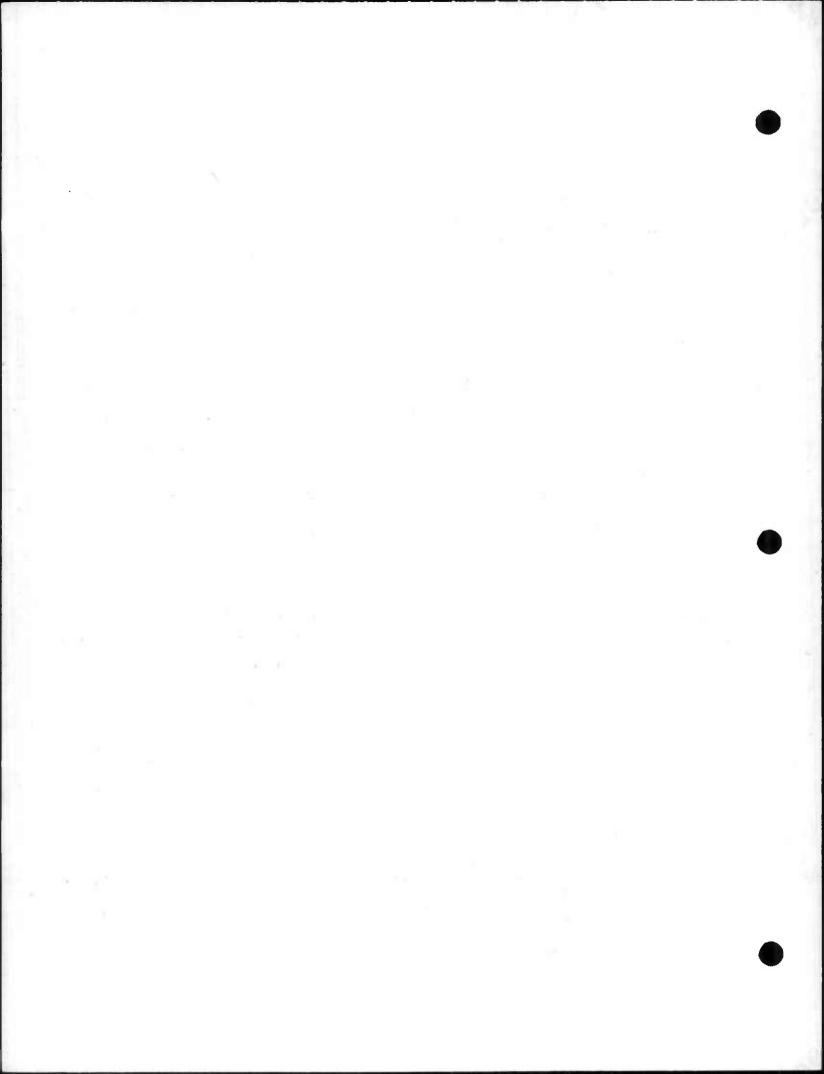
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

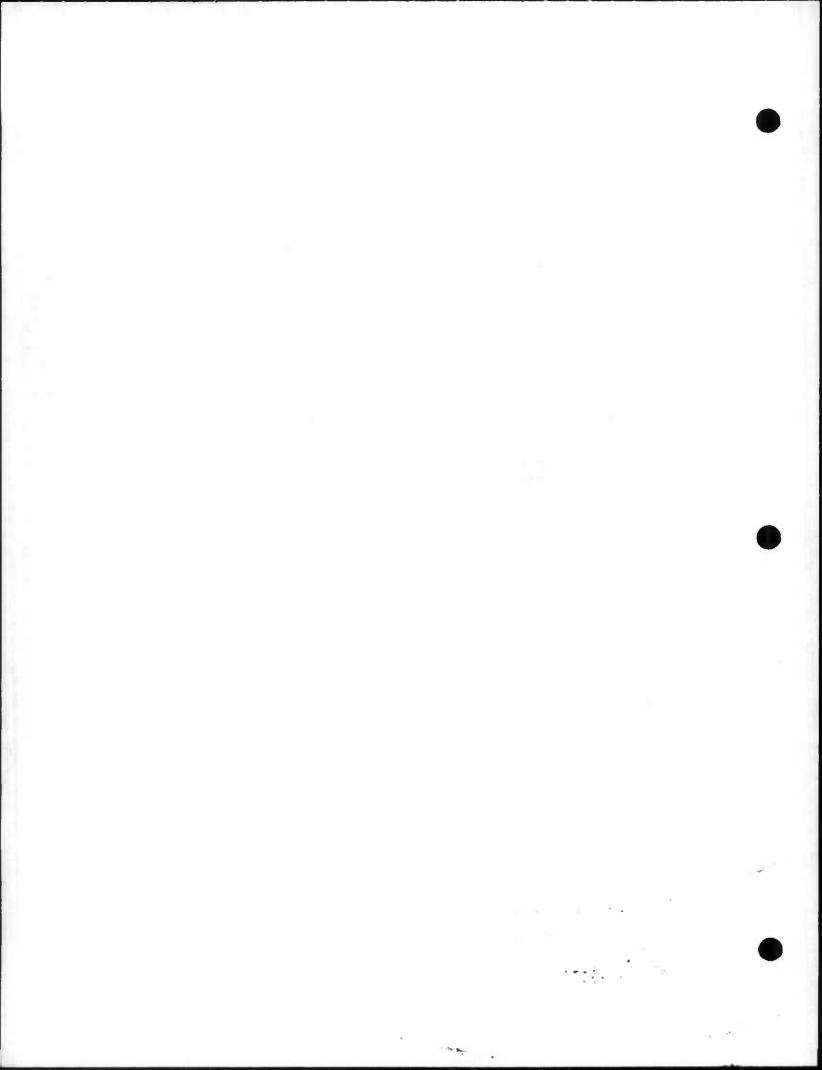
	HEGISTHAN			JERTIF	CATE	JE DEAL	п	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) RITA	WEI	NER			MONTH DAY VEAR			3. TIME OF DEATH 4:40am			
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs.		thday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DAT		7. DATE OF BIRTH (Month, Day, Year)	RTH 6. B		BIRTHPLACE (State or Foreign Country)		
	219-03-6573 9a. FACILITY NAME (If not institution, give s	1 M 2 F	88	YRS.		WN OR LOCATIO			DEC. 15,1906 NORTH			
6	JEWISH CONVALESCE	NT CENTER				BALTI		,	J. 000		TIMORE	
DIRECTOR		RESIDENCE OF DECEDENT									10d. INSIDE CITY	
	MARYLAND N	I/A		BA	LTIMOR				LIMITS?			
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BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES 2 NO					13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yas or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:					
TED	15. DECEOENT'S EDU (Specify only highest grade			DECEDENT'S	rork done durin	PATION g most of working	2	16b. KIND OF BUS	SINESS/INC	DUSTRY	WHITE	
COMPLET	Elementary/Secondary (0-12)				e retired.)		FOOD					
E CO	17. FATHER'S NAME (First, Middle, Last) SIMON]	ROMAN			18. MOTHER'S NAME (First, Middle, Melden Surname) SARAH GARRISO						
0 8	19a. INFORMANT'S NAME (Type/Print)							oute Number, City or Town		Code)		
-	MRS. SYLVIA RAE L	ESTZ	T 201 01 40				RAN	DALLSTOWN,				
	1 Densition 5 Dens											
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSER		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.								
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CARSE (Finel disease or condition resulting in death)	complications that List only one cause	caused the caused like on each ill	ne.	ot enter the	mode of dyir	ng, auch	TOWN ROAD as cardlec or reapli	retory an	reat,	Approximate Interval Between Onset and Death	
		1	OR AS A CONS):						5485	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									Z482		
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST d. DS PIRATION PROVINCE										Near	
EDICAL	Hehalasi	<i>or</i> .			1 YES 2	Do	+	COMPLETION OF CAUSE OF DEATH?				
N.	DID TOBACCO USE CONTI	RIBUTE TO CAU	SE OF DE	ATH YES	S NO	UNC	RTAIN				1 TYES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ACE OF DEATI					1.79			
14SI	1 YES 2 NO	1 Inpatient 2 E			4 (N. Nurettig	-		Other (Specify)				
ву Рь	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		28b. TIME INJU	JRY	WORK?	- 1	28d. DESCRIBE NOW IN	IJURY OC	CURED		
	3 Suicide 6 Could not be building, atc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										loute Number,	
COMPLETE	29e. CERTIFIER 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE							o the cause(s) and man			and menner sa stated.	
8	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LATE SHONED (Month, Day, Year										(Month, Day, Wer)	
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert B. Kroopnick Nio 8680 Liberty Plaza Mill Randollstown MP 2133										110 120	
	MAY 2 3 1995	32. REGISTRAR'S	S SIGNATURE	K	J- 00 4	y viac	u III	TII KOUKO	117400	un,	14 5 C(13)	



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Leet) 2. DATE OF DEATH 3. TIME OF DEATH MAY **GLADYS** WILLIAMS 1995 08:00 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. DAYS 1 M 2 V 229-20-0573A 69 July 27, 1925 Virginia 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Agnes Hospital Baltimore n/a RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO permit. FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 120 North Mt. Olivet Lane 21229 USA after death. Page 6 may be retained by the hospital or attending physician.. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 1 Merried 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced Bl.ack 15. DECEOENT'S EDUCATION 18e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) College 2 Designer Self employed at once 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) BE James Monroe Sallie Bowie notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Warren Williams 120 North Mt. Olivet Lane Baltimore, MD 21229 must be 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State May 18 OATE Burlel 2 Cremetion 3 R 4 ☐ Donation 6 ☐ Other (Specify) Arbutus Memorial Park Baltimore County, MD the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LAND 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway 1 Baltimore, Maryland 21216 8 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, and completely filled in by burial, cremation, or remo ahock, or haart fallure. List only one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) 06 · conces OUE TO (OR AS A CONSEQUENCE OF): 04 event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 if any, leading to immediate physician prior CAUSE Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): the attending pl that initiated events resulting in death) LAST 6 PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE and t PERFORMED? shows any Health a 1 TYES 2 NO OF DEATH? 1 TYES 2 NO t. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate h HOSPITAL: ☐ Inpetient 2-ER/Outpetient 3 ☐ DOA 1 - YES 200 NO 4 Nursing Home 5 Residence 6 Other (Specify) 6 27, MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Netural 5 Pending 1 YES 2 NO After 1 BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 28 Is 8 Could not be ED DIRECTOR: / determined COMPLET Item S S 29e, CERTIFIER (Check only one)

2 GERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 ho 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner es stated. 396. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ybar) 305 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 900 Caton StAgn connine Soun dess 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 3 1995



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TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		
Edith	C.	Walsh	May 18	199	

	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH									
	Edith C. Walsh						May		199	5	10:45 pm						
	4. SOCIAL SECURITY NUME	BER	5. SEX 1	6. AGE (In yrs. Is	est birthday)	IF UNDE	R 1 YEAR	IF UNDER 24		7. DATE OF	Day Ward		8. BIRTH Count	IPLACE (State or Fore	ign		
	220-54-8717	74	74 YRS.			HOURS	MIN.	Aug. 8, 1920			Maryland						
~	Se. FACILITY NAME (If not in					9b. CIT		OR LOCATION				9c. COU	NTY OF D				
DIRECTOR	Chapel Hil		ing Home				Rai	ndalls	tow	n			Bal	timore			
<u>ي</u>	10e. STATE	10b. COUNT	Y		10c. CITY	r, TOWN	OR LOCA	TION						10d. INSIDE CITY			
듬	Maryland		Baltimor	e		R	Randa	allsto	wn					LIMITS?			
A	10e. STREET AND NUMBER						10	H. ZIP CODE				10g. CIT	10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	3801	Schnap	er Drive					2113	33			U.	S.A.				
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A		13.	WAS DE	CENDENT OF I	HISPAN	IC ORIGIN?	(Specify Yes	or No-	14. RACI	E — American Indian			
<u> </u>	1 Never Merried 2 3 Widowed 4 Divo			WAR OR DATES				2 X NO			an, etc.)		Spec	My:			
	15 DEC	EDENT'S EDU	CATION	er. D	ECEDENT'S		2001047							hite			
	(Specify only	y highest grade	completed)	(4	Give kind of w	vork done	during m	ost of working		16b. K	IND OF BUS	INESS/INI	DUSTRY				
ᆲ	Elementary/Secondary (0	0-12)	College (1-4 or 5-		Tea	ache	r			Par	ocial	Sch	001	& Balto.	Co.		
COMPLETED	17. FATHER'S NAME (First, M	fiddle, Last)						18. MOTHER	R'S NAI	ME (First, Mic			-	o ballot	00.		
HE	C	harles	Stewart	Walsh				1	Min	nie L	. Wo	oler	У				
2	19e. INFORMANT'S NAME (7			11	9b. MAILING	ADDRES	S (Street	end Number or	Rural R	Route Number	City or Town	, State, Zip	Code)				
F	Mrs. Ethel	Stang		:	3507 (Chap	man	Road	Ra	ndall	stown	, MD	21	133			
	20e. METHOD OF DISPOSITE 1 Burlel 2 □ Crematic		oval from State		AND DATE O			ame of		DATE			City or To				
	4 Donation 5 Other 21. SIGNATURE OF FUNERA			- Holy	Fami	ly (Ceme			5/22	Ran	dall	stow	n, Maryl	and		
	O L	L SERVICE LI	7.02	V				ND AODRESS Byers		CILITY							
j,	23. PART I. Enter the di	har	Myer	De		87	28 I	iberty	v R	oad	Randa	11st	own.		33		
	shock, or himmediate CAUSE (Fir disease or condition resulting in death)	aart fallure. nei	a. Malv	ise on each lin	a. Lyn	a.r.h			_					Approximatinterval Bet Onset and I	ween Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):																
- 1	PART ii. Other aignifica	nt condition	a contributing to	death but not	resulting in	n the u	nderiyin	g ceuse give	en in l	Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FIND			
EDICAL	Commen	1 000	tery p.5	dees a							PERFOR			COMPLETION OF CAL	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
	Consest	ue H	went 1	a. I u me				/						OF DEATH?			
ž	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	s 🗆	NO E	UNCER	RTAIN	1 🗆							
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLA	CE OF DEAT	H (Check											
2	1 TYES 2 NO		1 Inpetient 2		3 DOA	4 🗇 Nu		te 5 🗆 Resid	lence (6 🗆 Other (Specify)						
2 7		Pending Investigation	28e. OATE OF (Month, D	ay, Year)	28b. TIME INJU	OF JRY M	W	ORK? YES 2 N	10	26d. DESC	RIBE HOW IN	JURY OC	CURED				
3		Could not be determined	28e. PLACE O building,	FINJURY — At he atc. (Specify)	ome, ferm, st	traet, fec	tory, offic	a		261. LOCAT City or	ION (Street e. Town, Stete)	nd Number	or Rural F	loute Number,			
COMPLE			CIAN: To the best of) end manner ee stat			
	29b. SIGNATURE AND TITLE				mveetigetioi	i, itt nity t	ориноп, п				ia piace, end				ed.		
H	230. SIGNATURE AND TITLE	or CERTIFIED	1					29c. LICENS				29d. DAT	E SIGNED	(Month, Day, Year)			
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type	Print)		13 2	190	085			5/19	145			
	31. DATE FILED (MONTH, Day, MAY 2 3 19	· Ch	10005		10 0		Cec	ns Re	Dee 1	o /	Zenna	113100	wa	2113	ŝ		

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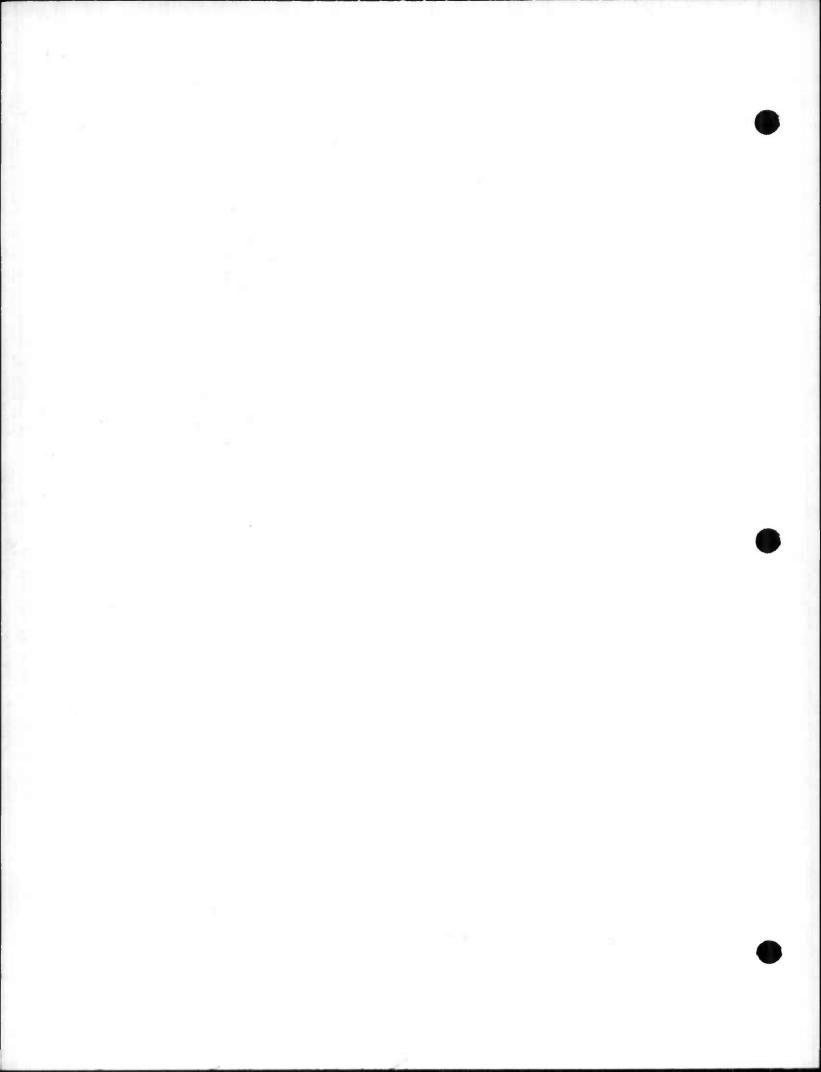
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

STATE OF MARYLAND / DEPARTMENT OF HE	EALTH AND MENTAL HYGIENE	
CERTIFICATE OF I	DEATH DEG NO	

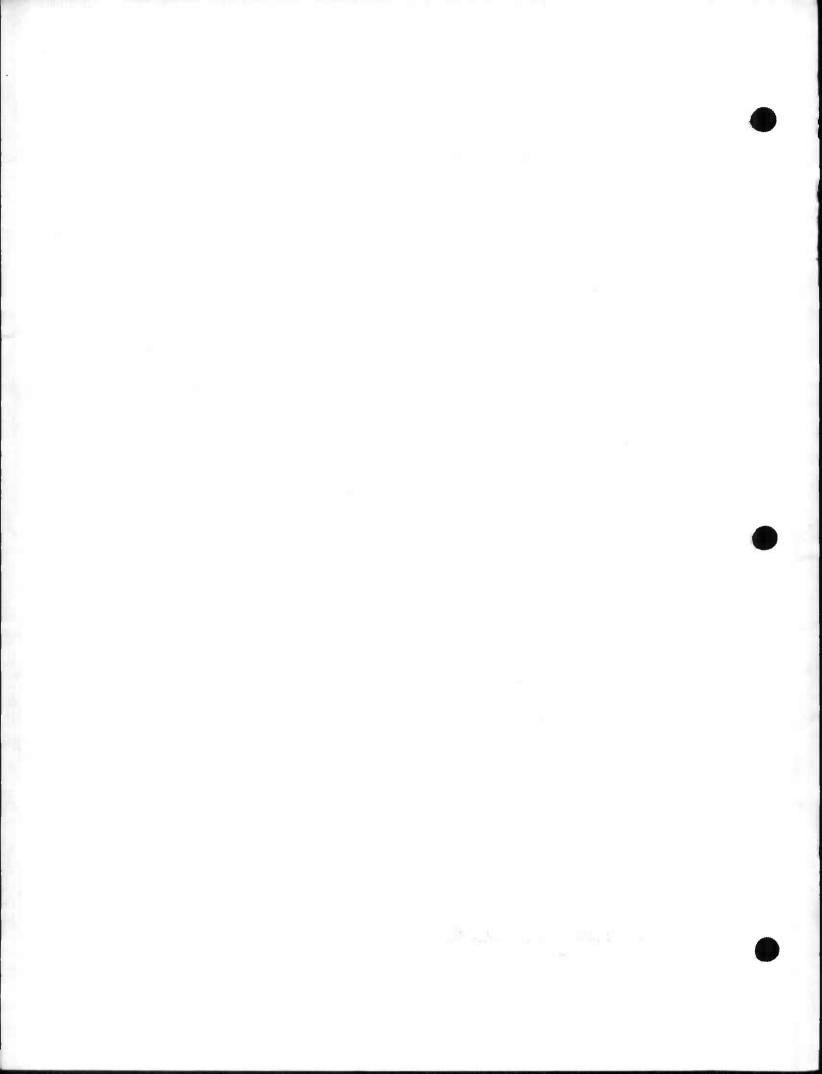
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF H	IEALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) RUSSELL F	ENT'S NAME (First, Middle, Last)					2. DATE OF DEATH DAY MONTH DAY 19, 1995 8:4				
	219-10-0563	1 X M 2 □ F 6	n yrs. lest birthdey) 9 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 09 09	8. BIRT	HPLACE (State or Foreign			
TOR	90. FACILITY NAME (If not institution, give street NORTH ARUNDEL I		BURNII		9c. COUNTY OF	ARUNDEL					
DIRECTOR	10a. STATE 10b. COUNTY	E ARUNDEL	10c. CIT	Y, TOWN OR LOCAL GLEN	BURNIE		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	10e. STREET AND NUMBER 523 ARUNDEL AT				21061		10g. CITIZEN OF				
B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 XYES IF YES, GIVE WAR OR DA WW 1	U.S. ARMED 2 NO TES	It yes, sp	ENDENT OF NISPAI ecity Cuben, Mexica 2 NO Specifi	NIC ORIGIN? (Specify Yei in, Puarto Rican, etc.) y:	Spec	E — American Indian, ik, White, atc. ://y: VHITE			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade on Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mose retired.) MPLOYED	st of working		SINESS/INDUSTRY				
	17. FATHER'S NAME (First, Middle, Last) WILMER WAGN		SELF E	MPLOYEL		ME (First, Middle, Maiden	Surname)	PANY			
TO BE	190. INFORMANT'S NAME (Type/Print) JOYCE M. WAGNER	2			nd Number or Rural i	Acute Number, City or Tow		21061			
	20e. METHOD OF DISPOSITION 1 Burlel 2 Of Cremation 3 Remove 4 Donation 6 Other (\$pecify)	al trom State	PLACE AND DATE ETRO	OF DISPOSITION (NE REMATOR	Y, INC.	5/20 CA	•	SVILLE, MD.			
	21. SIONATURE OF FUNETIAL SERVICE LICEN	L. Koul	man	RAYM 426	OND C. CRAIN H	FINK FUN	ERAL HO	ME 21061 NIE,MD.			
PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert felters. List only one cause on asch line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. ATTHICAL OF TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. ATTHICAL OF TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQU										
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29e. CERTIFIER (Check only one) 1 X CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29c. LOCATON (Street and Number of Rura City or Town, State)							nner as stated, d dua to the cause(
TO BE	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	IN (ITEM 27) (Type	Print)	29c. LICENSE NUN D4497		29d. DATE SIGNED				
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	HOSPIT

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL	HYGIENE REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)	A				2. DATE O	F DEATH DAY	, ,	EAR 3.	TIME OF DEATH	
			STAV AI	LBACH			MA	Y 15	1995	5	12:00P	
P.		4. SOCIAL SECURITY NUMBER 218-32-1865	1 X M 2 🗆 F 8		UNDER 1 YEAR HITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, I	Day, Year)	201/2	Country)	CE (State or Foreign	
2, 3 should	стов	99. FACILITY NAME (If not institution, give str 8204 WILSON	et and number) AVE	91		CVILLE	EATH		9c. COUNTY		MORE	
les 1,	ш	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCATI					7	d. INSIDE CITY	
permit, Pages	AL DIR	Mo Bai-	timore	P	ARKVI	LLE ZIP CODE			40- CITITEI	1	LIMITS? YES 2 NO T COUNTRY?	
1St	FUNERA		N AVE			21234			Us		COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Never Merried 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	It yes, spe	ENDENT OF HISPAI ecity Cuben, Mexico 2 NO Spect	en, Puerto Ric		or No— 14	RACE — Black, W Specify:		
r attend use as	ED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	18e. DECEDENT'S US	UAL OCCUPATIO	N	16b. K	IND OF BUS	NESS/INDUS		ILE	
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AND the hospit detached	ő	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA		ldle, Malden S	'umame)			
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MAR retained 5 should notified	2	190. INFORMANT'S NAME (Type/Print) WOLFGANG A	Ibach	19b. MAILING AD	1.11	nd Number or Rural	Balt				234	
		20e. METHOD OF DISPOSITION	20h	. PLACEAND DATE OF C	WILSO!		DATE	20c LOC	ATION - CIT			
LIIMORE, ath. Page 6 may by neral director, page		1 Buriel 2 Cremetion 3 Remo	val from State can	REEN MO	place)	METERY	5/19/9	Bal	itimo			
AL I IM death. Page funeral direct.		21. SIGNATURE OF FUNERAL SERVICE LICE		\cap	22. NAME AN	O ADDRESS OF FA	CILITY					
A a a a . X		Keent W	Leves	X	8800	CHAPEL > Hoxfo	ord R	d. Bo	elto.	bM	21234	
tours after d in by the or removal		23. PART I. Enter the diseases, or co ahock, or heart fallure. L	omplications that caused	d the deeth. Do not	enter the mod	de of dyling, suc	h as cerdle	c or reepire	etory erreel	,	Approximata	
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certificate ding physi hygiene pr	Ë	thet initiated evente resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
ne death the atten Mental H	0	d										
= 0 = =	JAL.	PART II. Other eignificant conditions	*	ut not resulting in t	he underlying	cause given in	Part i, 2	4a. WAS AN A PERFORM			RE AUTOPSY FINDINGS ULABLE PRIOR TO	
uires that signed b Health ar	MEDIC	Tarkmon 15 m								COMPLETION DF CAUSE OF DEATH?		
w requires been sign or, of Heal	Σ	DID TOBACCO USE C	ONTRIBLITE TO	CALISE OF D	FATH VI	ES NC				1 [YES 2 NO	
he law has be Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	ON RIBOTE TO	CAUSE OF B		ACE OF DEATH (Ch	1					
SICIAN: The Sician: The Sertificate It the State It the State It, or item	SIC		HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA 4	THER:	5 Residence		Specily)				
PHYSICIA this certil with the	H	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF			28d. DESC	RIBE NOW IN	JURY OCCUR	ED		
OING PHYS After this death with	B	2 Accident Investigation	20 - Bt 405 OF IN HIE			ES 2 NO						
TTEN TOR: after	TED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At nome, term, atree	et, tectory, office		28t. LOCAT	ON (Street an Town, State)	d Number or	Rural Route	Number,	
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THE HOSPITAL THE FUNERAL filed within 72 PORTANT: IF		29b. SIGNATURE AND TITLE OF CERTIFIER										
THE TO THE SE filed	BE	Ahuden &	oldonios	, m.D		29c. LICENSE NUI	-		► MA	W 17.	1995	
₽₽₩.	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE		nt)				1 1-1	1		
			Soldgever	711 We	ST AD	HI ST 1	Balto	. Ma	1. 21	211		
		MAY 2 4 1995	32. REGISTRAR'S SON	ATURE								



Pages 1, 2, 3

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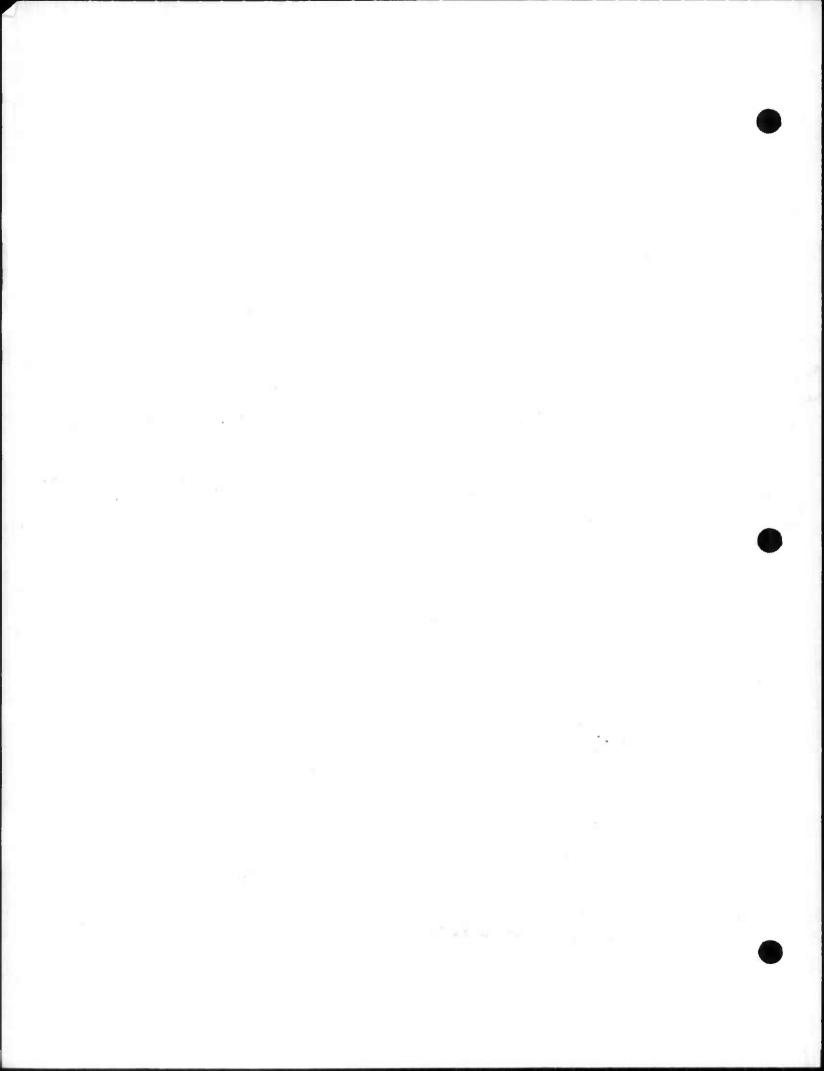
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BALLIMOR	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 ms	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
ME	r death. F	he funeral	examin
0	ours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fir be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 6:30 JOSEPHINE APPLEBY MAY 20 1995 8. BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) AUG. 3, 1925 1 M 2 XX 205-16-4696 69 PA. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CROWNSVILLE 1072 OMAR DRIVE ANNE ARUNDEL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD ANNE ARUNDEL CROWNSVILLE 1 TYES 2 THO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1072 OMAR DRIVE 21032 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, While, atc. 1 Never Married 2 Married 3. Widowed 4 Divorced BY 1 - YES 2 NO Specify WHITE ETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) College (1-4 or 5+) COMPL OWN HOME N/A HOMEMAKER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANK **GEISER** CORA EDNA WINTERS 띪 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KATHLEEN MILLER 1072 OMAR DRIVE CROWNSVILLE MD 2103 20s. METHOD OF DISPOSITION
107 Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE MD . VETERANS 5 - 23CROWNSVILLE MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
HARDESTY FUNERAL HOME P.A. 21054 arres ANNAPOLIS RD. GAMBRILLS MD 23. PART I. Entar the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haert fellure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition engertane 1 week resulting in dasth) arshan CERTIFICATION Sequantisity list conditions, DUE TO (OF AS A CONSEQUENCE OF): if sny, landing to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death-but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Durane heavy COMPLETION OF CAUSE 1 | YES 2 10 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 1 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO B 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D21684 GLENBURN12 CV. CYRIAC. MD 1600 CRAIN JOUY MD 21061

32 BEGISTRAR'S CHATURE

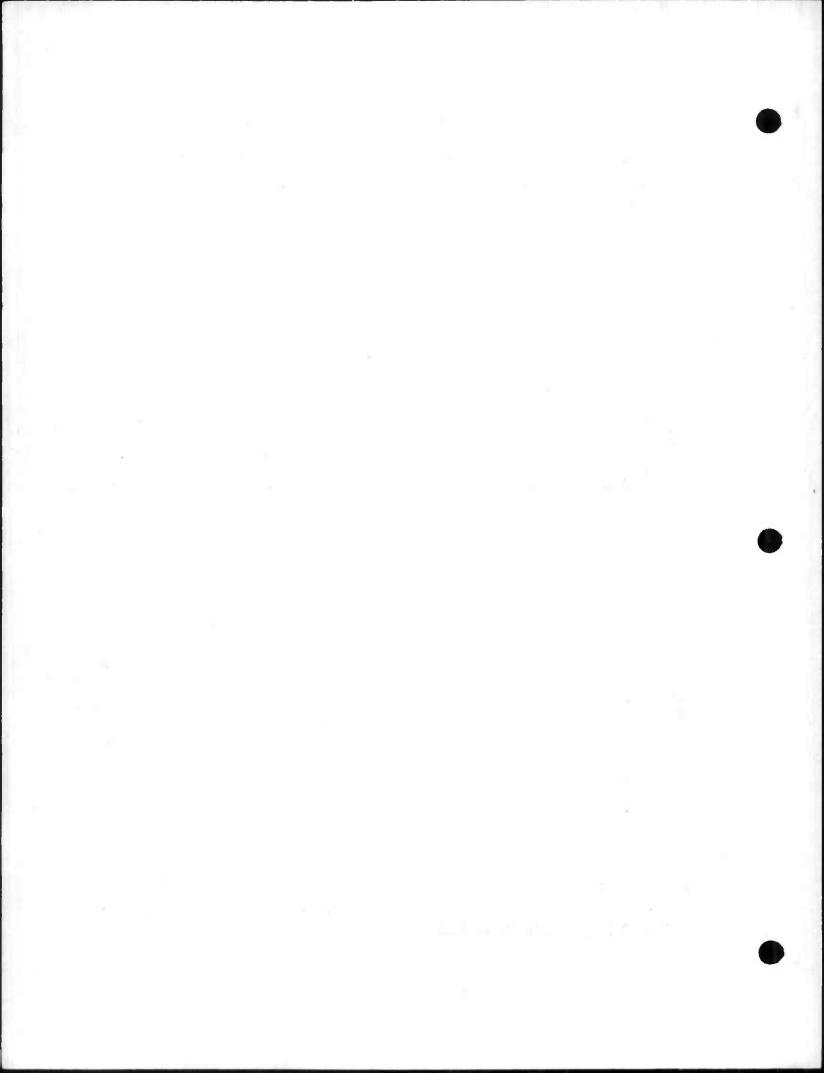


DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	A DECEMENTIO MANE OF A ANALYSIS OF										
	1. DECEDENT'S NAME (First, Middle, Lest) RONALD A. BARCLAY 2. DATE OF DEATH MONTH MAY 20 1995 3. TIME OF DEATH MAY 20 1995										
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last bi	irthday) I	F UNDER 1 YE	AR IF UNDER 24 HRS	7.0	ATE OF BURTH			ACE (State or Foreign
	unknown	YRS.	IONTHS DAY	YS HOURS MIN	DÊ	C. 29,1	975	Country)	IMORE, MD		
œ	9a. FACILITY NAME (If not institution, give			9		VN OR LOCATION OF	DEATH		7	NTY OF DEA	
<u>or</u>	JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a										
DIRECTOR	10a. STATE 10b. COUNT		1	10c. CITY, 1	TOWN OR LO			1	0d. INSIDE CITY		
	MARYLAND	n/a		BALTIMORE 101, ZIP CODE							XX X ES 2 NO
BA	1325 N. LUZER	NE AVENUE		21213				10g. CITIZEN OF			STATES
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARME	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify						14. RACE -	- American Indian
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	YES 2 NO OR DATES XX		If yea	YES 2 NO Spi		rto Rican, etc.)		Specify:	White, atc. BLACK	
TED	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	(Give	kind of worl	SUAL OCCUP	ATION most of working		16b. KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12) 9 TH	College (1-4 or 5+)		MOT use n		Laborer		V 21	nious	trac	too
OM	17. FATHER'S NAME (First, Middle, Last)		unc	.mp ro	ycu-		NAME (Fil	rst, Middle, Maiden		trac	ie s
BEC	RONALD W.	BARCLAY				JOA	N	MATTHEW:	S		
10	19a. INFORMANT'S NAME (Type/Print) GWENDOLYN S	NOWDEN				eet and Number or Rui					
	20a. METHOD OF DISPOSITION	NOWDEN	20b. PLACE AND	15		7 TH ST,	1				21218
	1XXBurial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	movel from State	VOSHE	lory or other	MEMOR					City or Town	IARYLAND
	21. SIGNATURE OF EUNERAL SERVICE L	CEMBER				E AND ADDRESS OF			2011071	LIN 9 11	IANTLAND
	I LOALS	on CAA	0	_	WM.	C. MARCI	H FH	1101	E. N	ORTH	AVENUE
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. MULTIPLE I	NJURIES AS A CONSEQUE	ENCE OF):							
RTIFICATION	disease or condition	b. DUE TO (OR /		NCE OF):							
ICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. DUE TO (OR A	AS A CONSEQUE	INCE OF):	the underl	ying cause given	in Part 8	PERFOR	IMED?	A	Onset and I
MEDICAL CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART ii. Other significant conditions	b. DUE TO (DR /	AS A CONSEQUE AS A CONSEQUE AS A CONSEQUE th but not reau	INCE OF):			in Part 8	24a WAS AN PERFOR	IMED?	Al O	ERE AUTOPSY FIND VAILABLE PRIOR TO OMPLETION OF CAL
DICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other significant conditions of the conditions of the conditions of the cause of the ca	b. DUE TO (DR /	AS A CONSEQUE AS A CONSEQUE th but not reached.	ENCE OF):	□ NO	UNCERTA		1 YES 2	IMED?	Al O	ERE AUTOPSY FIND VAILABLE PRIOR TO OMPLETION OF CAL
DICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. DID TOBACCO USE CONT	b. DUE TO (OR d. DUE TO CAUSE	AS A CONSEQUE AS A CONSEQUE th but not reau E OF DEATH 26. PLACE D	ince of): alting in t YES PF DEATH (OTHER:	UNCERTA	MIN 🗆	PERFOR	IMED?	Al O	ERE AUTOPSY FIND VAILABLE PRIOR TO OMPLETION OF CAL
DICAL	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition of the co	b. DUE TO (DR.) c. DUE TO (OR.) d	AS A CONSEQUE AS A CONSEQUE The but not reach E OF DEATH 26. PLACE 0 Outpatiant 3X JRY 1.2	YES TYES DOA O DOA THE DEATH (Check only of Check only only only only only only only only	UNCERTA	AIN 🗆	PERFOR	MED? ☐ NO	Al Ci	ERE AUTOPSY FIND VAILABLE PRIOR TO OMPLETION OF CAL
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BY PHYSICIAN: MEDICAL	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be	DUE TO (DR. DUE TO (OR. DUE T	AS A CONSEQUE AS A CONSEQUE AS A CONSEQUE th but not reat E OF DEATH 26. PLACE D Outpatiant 3X3 JRY 2 11 JURY — At homa, (Specify)	YES PF DEATH (DOA 4 Bb. TIME D INJURY 1:01 P Ferm, attret	Check only of Check only of CTHER: Nursing I Norsing I 28c.	UNCERTA tome 5 G Rasidence WORKY X YES 2 ND	MN	hther (Specify) DESCRIBE HOW III VER IN AU	NJURY OCC	O O I	Onset and E
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E COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 (Accident 3 Suicide 8 Could not be determined condition) 29a. CERTIFIER (Check only 1 CERTIFYING PHYS)	DUE TO (DR. DUE TO (OR. C. DUE TO (OR. d. TRIBUTE TO CAUSE HOSPITAL: 1 Inpartant 2 ERA 28a. DATE OF INJU (Month, Day, 16 5-19-95 28a. PLACE OF INJ building, atc. (AS A CONSEQUE AS A CONSEQUE The but not react Th	I YES PF DEATH (DOA 4 Bb. TIME D HAUDEN 1: 01 P Form, street DAD OCCURRED 1: 01 P	Check only of Check only only only only only only only only	UNCERTA- Home 5 G Rasidence INJURY AT WORK? YES 2 ND Inffica data and place, and den, death occurred at to	DRIVER	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW II VER IN AU OCATION (Street a City or Town, State) I MORE, MA Cause(a) and man	NJURY OCC TO / CAI and Number 24 00 BI ARYLAND aner as stete d due to the	URED R IMPAC	CT To Number, DDLE ST. Ind manner es state
ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART ii. Other aignificant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 (Accident Investigation of the Inve	DUE TO (DR.) DUE TO (OR.) C. DUE TO (OR.) d. IN DUE TO (OR.) DUE TO (OR.)	AS A CONSEQUE AS A CONSEQUE AS A CONSEQUE th but not reat E OF DEATH 26. PLACE D YOUtpatlant 3X1 JRY 21 JURY — At homa, (Specify) R (Consequence) (Specify) R (Consequence)	YES PF DEATH (DOA 4 NUMBER OF PROPERTY OF	(Check only of Check only on the Check of Check only only of Check only of Check only of Check only only only only only only only only	UNCERTA tome 5 Rasidence INJURY AT WORK? YES 2 ND wiffica data and placa, and d n, death occurred at t	DRIVER	PERFORI 1 YES 2 Wher (Specify) DESCRIBE HOW II VER IN AU OCATION (Street a City or Town, State) I MORE, MA Cause(a) and man	NJURY OCC TO / CAI and Number 24 00 BI ARYLAND aner as state d due to the	URED R IMPAC	CT to Number, DDLE ST.

DHMH-18 Rev 1/89



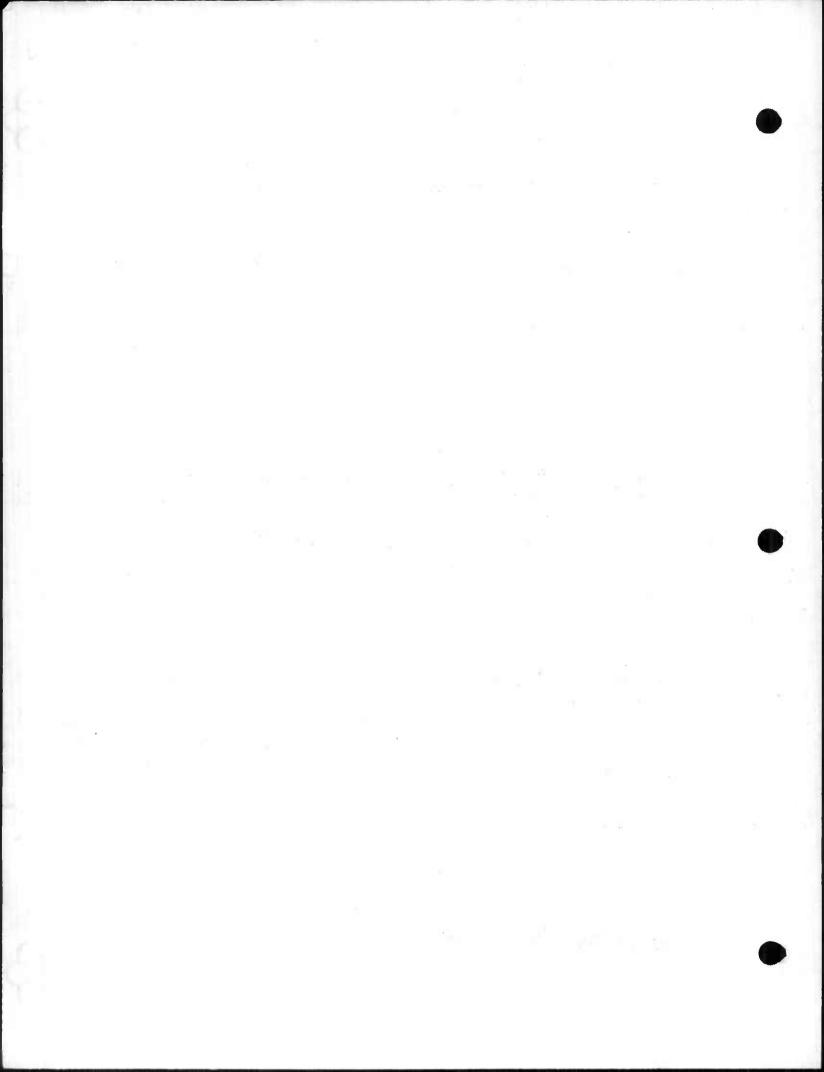
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Pages 1, 2, 3 should

ITEM: 24a, PER DR. FILM G-723 5/24/95 t.t

	1 - STATE REGISTRAR	STATE OF MARYLAND) / DEPAR	TMENT OF	HEALTH AND	MENTA	L HYGIENE			
	1. OECEOENT'S NAME (First, Middle, Last) Mildred K. Benne					2. DATE MONT Mau	OF DEATH	1995 YEAR	3. TIME OF DEATH 5:10 A. M	
		SEX 6. AGE (In yrs.	· last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN,	7. DATE (Mont	OF BIRTH In. Day, Year) Ch 27, 1	922 a. BIRT Coun Ma	HPLACE (State or Foreign try) Lyland	
TOR	Meridian Nursing H		en		on Location of o			timore		
DIRECTOR	10e. STATE 10b. COUNTY	ltimore	10c. CIT	Y, TOWN OR LOCA	TION Ultimore		· · ·		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 500 Virginia Ave	500 Virginia Avenue				101. ZIP CODE 21204				
A	11. MARITAL STATUS 12. 1 Never Married 2 Married 3 Wildowed 4 X Divorced	NO	2 / 2 / 4 U.S., 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No					E — American Indian, ck, White, etc.		
COMPLETED	(Specify only highest grade com	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12th qrade CL						NESS/INOUSTRY	<u> </u>	
199. INFORMANT'S NAME (Type-Print) 190. INFORMANT'S NAME (Type-Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9939 Nearbrook Lane, Baltimore, MD 21234 200. PLACE AND DATE OF DISPOSITION (Name of organizery, cremately or other place) 100. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101. Date 202. LOCATION — City or Town, State organizery, cremately or other place) 102. NAME AND ADDRESS OF FACILITY 103. SIGNATURE OF FUNERAL SERVICE LICENSEE 104. Date 205. LOCATION — City or Town, State organizery, cremately or other place) 105. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107. Date 208. LOCATION — City or Town, State, Zip Code) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109. MAILING ADDRESS (234	
CERTIFICATION	23. PART L Enter the diseasea, or camplications that caused the defit. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Appninted METASTATIC CANCER BUE TO (OR AS A CONSEQUENCE OF): CANCE R DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PHYSICIAN: MEDICAL C	PART II. Other significant conditions co		In the underlying couse given in Part i.			24e. WAS AN AUTOPSY PERFORMED?		b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
NAN	DID TOBACCO USE CONTRIBU	26. PL		S NO C	UNCERTAI	N 🔲				
HASIC	I III	OSPITAL: Inpatient 2 ER/Outpatient 28e. DATE OF INJURY	3 🗆 DOA		ne 5 🗆 Residence		her (Specify)			
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	JRY W	DRY AT DRK? YES 2 NO	28d. OES	SCRIBE HOW IN.	JURY OCCURED		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, s				LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED		: To the best of my knowledge, in the bests of exemination and/							a) and menner ea stated.	
TO BE C	296 SIGNATURE AND TITLE OF CERTIFIER Raynand A	rezem P.	A	Defeat)	29c. LICENSE NUMBER D34184			29d, DATE SIGNED (Month, Day, Year) 5/19/95		
	RAYMOND A.H		A 78	F01 401	RKRD.	# 3	00,70	به وکصاد	mp21204	
	MAY 24 1995	32 REGISTRAR'S SONATURE	•							

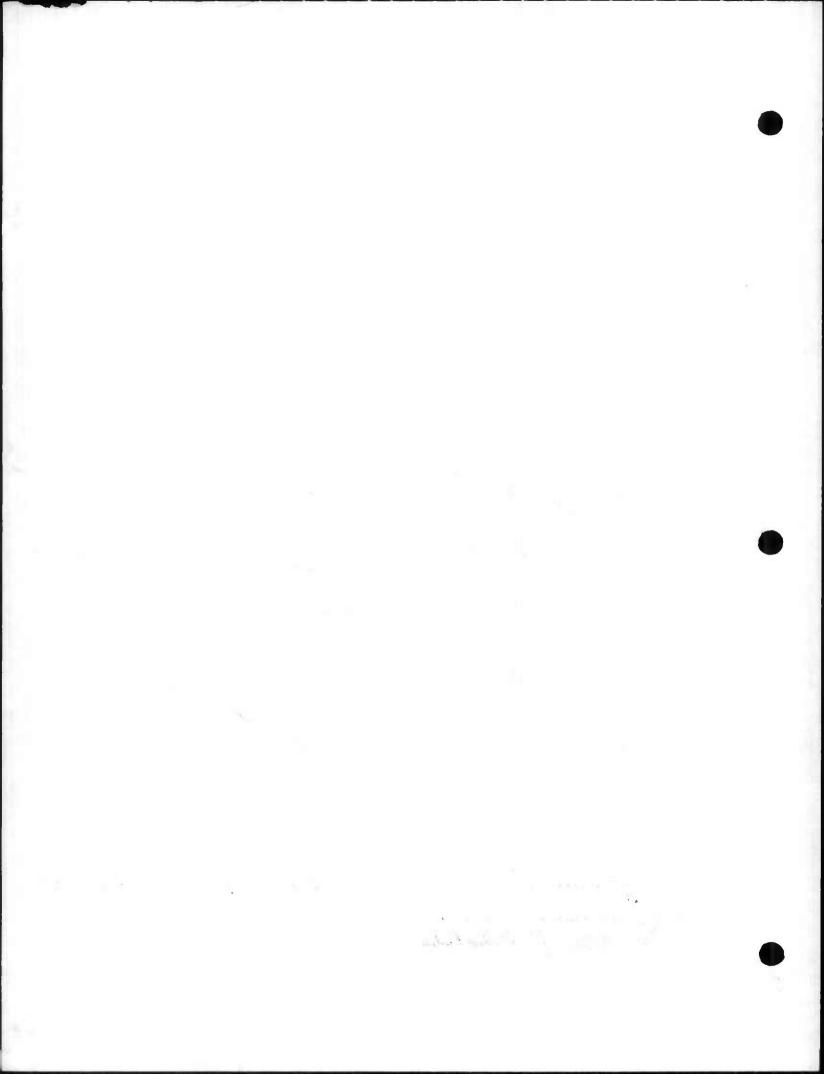


ì	tea	- Property
	PRITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death	COAL DIDECTOR. After this cardificate has been signed by the attendion physician and commission filled in by the time
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	OU.	.5
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 5 the state begin of Health and Merital hygher point to burial commandor, or embroal.
this cert with the
ENDING P IR: After to ler death v
OR ATTE DIRECTO hours aft
HOSPITAL OF FUNERAL DIF within 72 hou

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	, Middle, Last)						DUAN		2. DATE OF DEATH			3. TIME OF DEATH
		Natali	e Bru	linski							May 20		95	10:30 PM
		4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs.	. last birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH	1.0		PLACE (State or Foreign
		213-03-16	46	1 🗆 M 2 🔀 F	84	4 YRS.	MONTHS	DAYS	HOURS	MIN.	05/05/10			oland
shoul	FUNERAL DIRECTOR	9a. FACILITY NAME (If not in	stitution, give a	treet and number)			9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE	EATH 9c. COUNTY OF DEATH			
2, 3 should		201 S. Ch	ester	St.			I	3 a 1 t	cimor	re			N/A	
		RESIDENCE OF DEC	10b. COUNT	Y		10c. CIT	CITY, TOWN OR LOCATION							10d. INSIDE CITY
Pa.		MD		N/A			a1ti							LIMITS?
emit		10e. STREET AND NUMBER							of, ZIP CODE	E		10a. CIT		1 X YES 2 NO
physician. burial-transit permit. Pages 1.		201 S. Ch	ester	St.					212	231			USZ	
physician. burial-trar		11. MARITAL STATUS		12. WAS DECEDEN						C ORIGIN? (Specify Yea	or No-	14. BACE	- American Indian	
	BY F	1 Never Married 2 📆 3 Wildowed 4 Divo		IF YES, GIVE V	YES 2	XMO			pecify Cuba S 2 TNO		, Puerto Rican, atc.)		Specify	
or attending r use as the	EO B		EDENT'S EDU						21					White
by the hospital or att be detached for use at once.	LETE	(Specify on)	y highest grade	completed)		(Give kind of life. Do NOT u	work done	during m	iost of workin	g	16b. KIND OF BUS	SINESS/INI	DUSTRY	
od fo	곱	Elementary/Secondary (0-12) College			+)		ocei				Groo	erv	Sto	re
by the hospital be detached for at once.	СОМР	17. FATHER'S NAME (First, M	iddle, Last)			GI	oce.		18. MOTH	ER'S NAM			500.	
	TO BE CO	Frank Kruszewski					18. MOTHER'S NAME (First, Middle, Melo Josephine Mi						zewsl	ki
retained 5 should notified						19b. MAILING	ADDRES	S (Street	and Number	or Rural R	oute Number, City or Town	n, State, Zip	Code)	
y be relage 5 :		Theodore	J. Bi	culinsk	i	201	s. (Ches	ster	St.	, Balto.	, MI	D 21:	231
age 6 may be director, page er must be		20s. METHOD OF DISPOSITI		ovat from State		CEAND DATE			lame of		DATE 20c. LO	CATION -	City or Tow	n, Stata
age 6 directs		a Donatton 3 Dother (Specify) Holy Rosary Cemetery 5/24 Balto., MD 22, NAME AND ADDRESS OF FACILITY												
death. Page 6 may be retained funeral director, page 5 should i. examiner must be notified		21. gameone of Fonesia	1)/	7 2	//						um eber Fun	era1	Hom	ne l
. 27		dans	J 2	. ON	15	/		401	S.	Che	ster St.	. Ba	1to.	
NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after this certificate has been signed by the attending physician and completely filled in by the saft with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removemarked, or Item 23 shows any Injury, or other traumatic event, the medical	PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Demontia Alzheimer's type and your conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet intilated events resulting in death) LAST DUE TO (OP AS A CONSEQUENCE OP): LISTORY OF STROKE DUE TO									Interval Between Onset and Death JEUIS WERE AUTOPSY FINDINGS MAILABLE PRIOR TO DOMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
NDING R: After r death is ma	D BY	2 Accident 3 Suicide 8	Could not be	28e. PLACE O building.	F INJURY — At atc. (Specify)	home, ferm,	m street, 1ec			-	281, LOCATION (Street a	nd Number	or Runal Ro	ute Number,
OR ATTE DIRECTOR hours afte	ш	4 Homicide	determined								City or Town, State)			
Z 7 N =	COMPLE										o the cause(a) and man lime, data and place, and			and manner as stated.
TO THE HOSPIT TO THE FUNER DE filed within 7	BE C	296. SIGNATURE AND TITLE	OF CERTIFIER	0	/	44.			29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED (Month, Day, Year)
5 5 3 W	5	STAPPRE	nue	Line	er	MI)			D4	39	09	•	5-2	3-95
		30 NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH (TEM 27) (Type				0	7.			,
1)		Stephanie 31. DATE FILED (Month, Day,	Linde	1 20 DECISION	R'S SIGNATURI	STEK	7	410	2	150	1+0. M	0	2/2	24
7		MAY 2 41		who drude	arland	4								



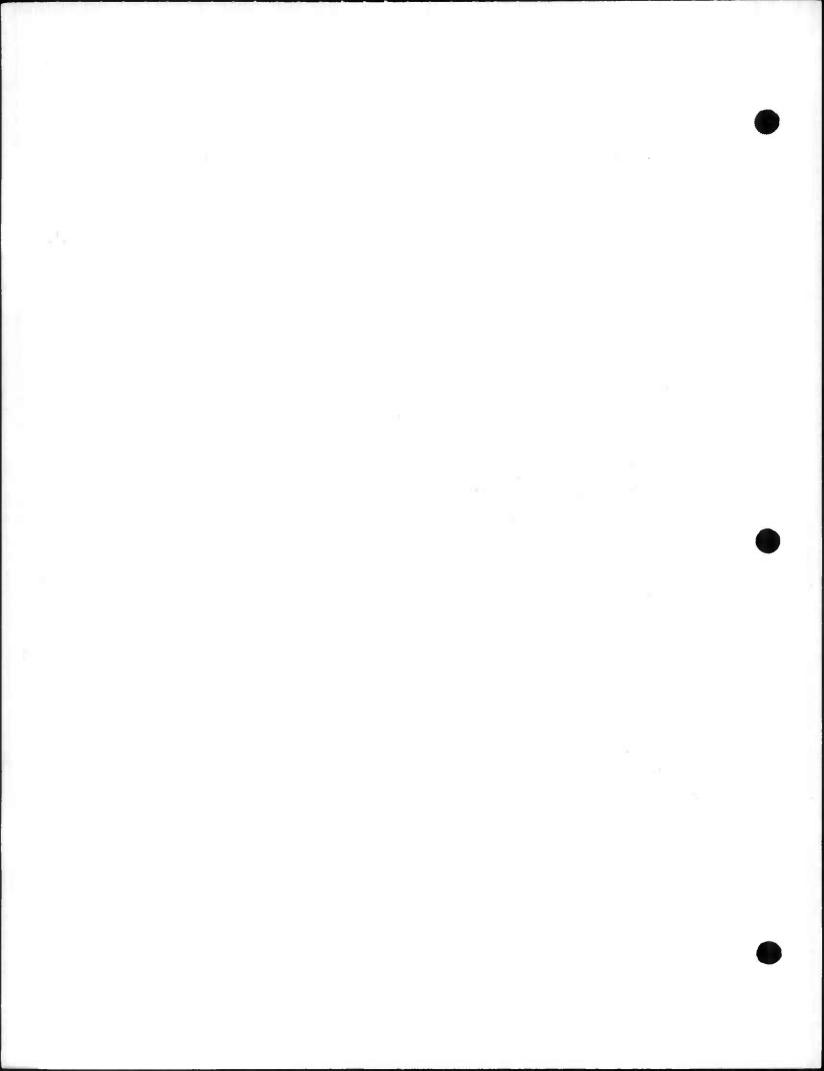
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

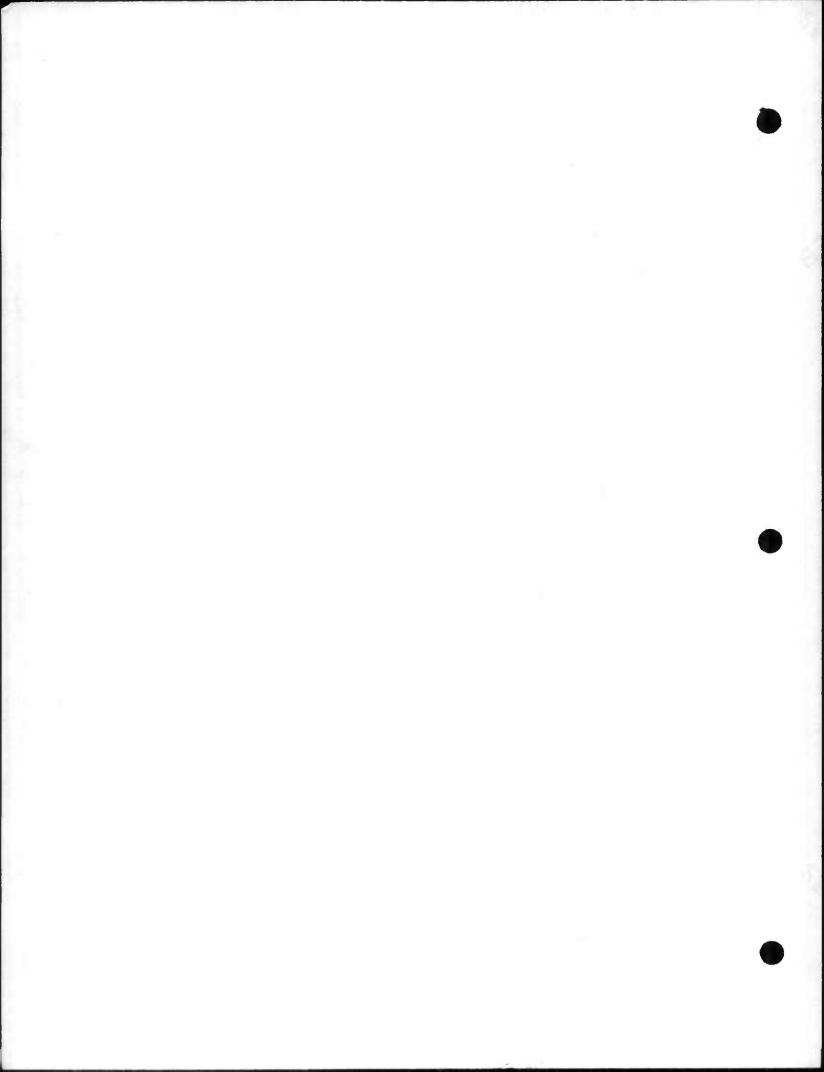
	REGISTRAR		CE	RTIF	ICATE	OF	DEATH		REG	G. NO.			
	1. OECEDENT'S NAME (First, Middle, Last)			. 12.					DATE OF DE	ATH			3. TIME OF DEATH
- 4	MARY K. BENTL	EY							MONTH IAY 1	D/	1995	YEAR	2-24A "
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t hirthriay)	IF UNDER	1 VEAR	IF UNDER 24 HRS	\rightarrow	DATE OF BIR		1990	A BIRTI	HPLACE (State or Foreign
- 1	216-30-5391	1 □ M 2X F	62	YRS.	MONTHS	DAYS	HOURS MIN	M	(Month, Day, RCH 31	Year)	22	Count	ny)
		7474	- 02		211 2121		OR LOCATION OF	_		, 15			INGTON, DC
or I		9e. FACILITY NAME (if not institution, give etreet end number)						DEATH	1			INTY OF D	
6707 McCAHILL TERRACE LAUREL PRINCE GEORG									E GEORGE				
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		100 CIT	Y, TOWN C	B LOCAT	100						
區				100. 011	r, rown c								10d. INSIDE CITY LIMITS?
											1 TYES 2 NO		
₹	106. STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY?									WHAT COUNTRY?			
FUNERAL	6707 McCaHILL TERRACE 20707 USA												
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No									E — American Indian,			
BY	3 Widowed 4 Divorced										AUT IE		
	15. DECEDENT'S EDUC (Specify only highest grade		16a. DE(CEDENT'S	USUAL O	CUPATIO	ON st of working		166. KIND	OF BUS	SINESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	- Itte	Do NOT us	e retired.)	rumy mo	at or working						
<u>a</u>	12 2			Ana	lyst					U	S Gov	ernme	nt
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S	NAME (First, Middle,	Maiden	Sumame)		
E	PAUL HONOR						MARY C.	FR	EDRICH	S	I be be to		
0	19e. INFORMANT'S NAME (Type/Print)		198	MAILING	ADDRESS	(Street o	nd Number or Rui	al Bouts	Number City	or Town	o Stota Zi	n Codel	
임	SAMUEL P. CHALFANT, J	R.	6	707 M	cCAH1	LL TE	ERRACE,		AUREL.	OF TOWN	MARY		20707
1	20e. METHOD OF DISPOSITION												
	1 Burlel 2 X Cremation 3 Remo	oval from State	20b. PLACE A cemetery, cres				ma of CREMATORY	l				City or To	
	4 Doparton 5 Other (Specify)		BALTIMO	ORE WA	- Y				5/19	LAU	REL,	MARYL	AND
	THE SHALL SERVICE LIC	FUREE U			22.1	NAME AN	ID ADDRESS OF	FACILI	FLECI	K FU	NFRAL	HOME	, INC.
	17-00	1	~		7	601 5	SANDY SPR	ING	ROAD,	LAU	REL,	MARY	LAND 20707
	23. PART I. Enter the diseases, or o	omplications that	caused the day	eth. Do n									
	snock, or neert fellure.	List only one caus	e on eech line.		7		de or dynig, s	0011 01	s cardiac or	respii	ratory si	1001,	Approximats Interval Batween
1	IMMEDIATE CAUSE (Final disease or condition)												
	disease or condition a. In out was Congested Heart Falce - Cardio - 1494 DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF): DUE TO (OR AND A CONSEQUENCE OF):												
		DUE TO	OR AS/A CONSEC	UENCE OF	7: /		0			1	m	w John	5
z I	Sequentially list conditions,	. Hut	erion	cle		C	aco	La	ovaso	Mo	· De	each	16 YEARS
CERTIFICATION	if any, leading to immediate	DUE TO (OR AS A CONSEC	UENCE OF	7:								,
<u>5</u>	CAUSE (Disease or Injury												
<u> </u>	that initiated events	DUE TO (OR AS A CONSEC	UENCE OF):								
8	resulting in deeth) LAST	1											Į.
- 11	PART II. Other significant conditions	a anat-lhutian to	la eth bud t	- let - I									
EDICAL	CHRUNIC MY	RULLM	W.C. A	STIL	n the un	derlying	cause given	in Par	t I. 24a. V	ERFOR	AUTOPSY MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	CHOOKIC MY	teolem	05 60	PUR	CM/	17			. 10	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
													1 - YES NO
z I	DID TOBACCO USE CONTR	RIBUTE TO CAU	JSE OF DEAT	TH YE	S \square N	10	UNCERTA	I NI					
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL			OF DEAT									
<u> </u>	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER	l:	8 S Residence		Oth - = (0/	4.1			
Ì₽	27. MANNER OF DEATH	28e. DATE OF I		28b. TIME		28c. INJ		_	d. DESCRIBE	• •	CHIBA UC	CURED	
	Netural 5 Pending	(Month, Day	(, Year)	INJ		WO	RK?		a. DEGONIDE		100K1 OC	CORED	
⋒	2 Accident Investigation	26e PLACE OF	IALHIDY At hos		111111111111111111111111111111111111111			1					
	3 Suicide 8 Could not be 4 Homicide determined	building, a	INJURY — At hor tc. (Specify)	ne, rarm, a	treet, lecto	жу, опте	•	281	City or Town,		nd Numbe	r or Rural F	Toute Number,
	1 XV-5010												
ᆲ	29e. CERTIFIER Check only	CIAN: To the best of n	ny knowledge, des	th occurre	d at the ti	me, date	and place, end d	ue 10 11	he couse(s) er	nd men	ner as sta	ted.	
COMPLET	one) 2 MEDICAL EXAMINER) end manner ee stated.
	291-BIGNATURE AND TITLE OF CENTURER	11			-		29c. LICENSE N						
	4 ten - N ////												
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH	10%	2		DIS	6	6	- 1		0 //6	111
	. 4/ / /						1.1						
	Pennis & Schuner		201 CA	reel	PP	AK D.	14/01	. (CHURE	11	ap	207	45
	MAN O A 1005	42: REGISTRAR	SIGNATURE		10-1				-				
H	MAT 2 4 1995 YM	V IN IMPROPER	ALAN.										



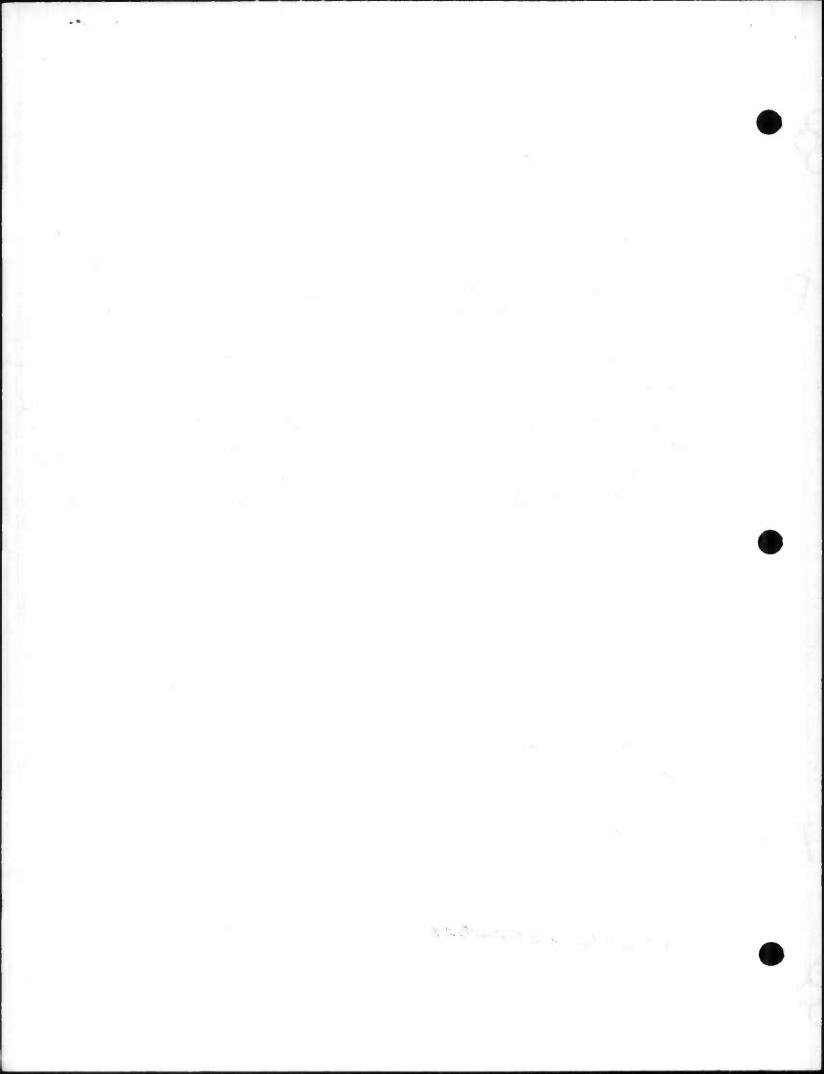
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CION	200	

	IO THE HUSPIAL OF ALLENDING PHYSICIAN: The law requires that the death certificate be emounted without all the now, the retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely thank in by the tuneral director, page 5 should be detached by use as the funital-frame team.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to be the committee of the state of the st	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	FOR STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAI ERTIF	RTMENT OF H	EALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, AROUN, LANCE TO DE C		Bose				2. DATE OF DEATH DATE MAY 19,19	Y YEAR	з. тиме от реати 6:18 а м		
	4. SOCIAL SECURITY NUMBER 215-37-2144	s. sex s. AGE (fr yrs. a. 1√√2 M 2 □ F 82				SEPT. 16, 15	B. BURD Close	THPLACE (State or Foreign			
DIRECTOR	THE JOHNS HOPKIN RESIDENCE OF DECEDENT	NS HOSPITA	L		BALTIM	ORE CIT	507.7	So. COUNTY OF	DEATH		
2.7	MARYLAND 10s. STREET AND NUMBER	HOWARD		10c. C/7	COLUMBIA		10d. INSIDE CITY LIMITS? 1 □ YES 2 MO				
ERA	I ND I	WHAT COUNTRY?									
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 2 XXWMdowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARMED IS. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. If yes, specify Cubis, Maxican, Puerto Rican, etc.)						CE — American Indian, ck, White, etc. cdy: Indian		
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION Se completed) College (1-4 or 5 +	/9	CEDENT'S We kind of Do NOT u	USUAL OCCUPATION work done sturing most relief.	ON at of working	166. KIND OF BUS	INESS/INDUSTRY			
MP	Unavailable	Unavaila	ble	SAL	ES		IMPORT/	EXPORT BU	SINESS		
00	17. FATHER'S NAME (First, Middle, Leat)						AME (First, Middle, Maiden	Sumeme)			
BE	AMARANDRA BOSE 19a. INFORMANT'S NAME (Typo/Print)						LATA GHOSH				
2	KRISHNA PAL		1235				JANNA MARYLA LUMBIA, MARYLA		2-017.7		
	20a. METHOD OF DISPOSITION 1 □ Burlai 2 □ Cremation 3 □ Rec 4 □ Donation 5 □ Other (Specify)	movel from State	considery, one	AMMERICAL DE D	OF DISPOSITION (No Inter place) ASH I NGTON		Allertine Inc.	EL, MARYL			
١.	21. BIGNATURE OF FUNERAL-SERVICE S	DENSEE	1		1	D ADDRESS OF F	FLECK F	UNERAL HO	ME, INC.		
	atall	Lucag	24		- Insertic		RING ROAD, LAU	Comme Constant	LAND 20707		
	23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one deute-onlesch light. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiac arrest										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL CI	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. (DVDVQVY) artery disease. 24a. WAS AN AUTOPSY PINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO										
AN	DID TOBACCO USE CONT	TRIBUTE TO CAI				UNCERTAI	N 🗆				
SICI	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER:						
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Da	INJURY	28b. TIM	IE OF 28c. INJI		8 Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE Of building,	FINJURY — At ho	me, farm,	street, factory, office		281, LOCATION (Street e. City or Town, State)	nd Number or Rural	Route Number,		
COMPLET							to the cause(s) and man		(e) end menner ee stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE LOUND VO	ne Su	raen	Res	ident	29c. LICENSE NU	MBER 669	29d. DATE SIGNE	D (Month, Day, Year)		
	Elaine Tsena	Johns	Itook	M 27) (Type LAS	Hospita	1 600	N. Wolf	e St.	21205		
	MAY 2 4 1995	32. Aggistan	or land								

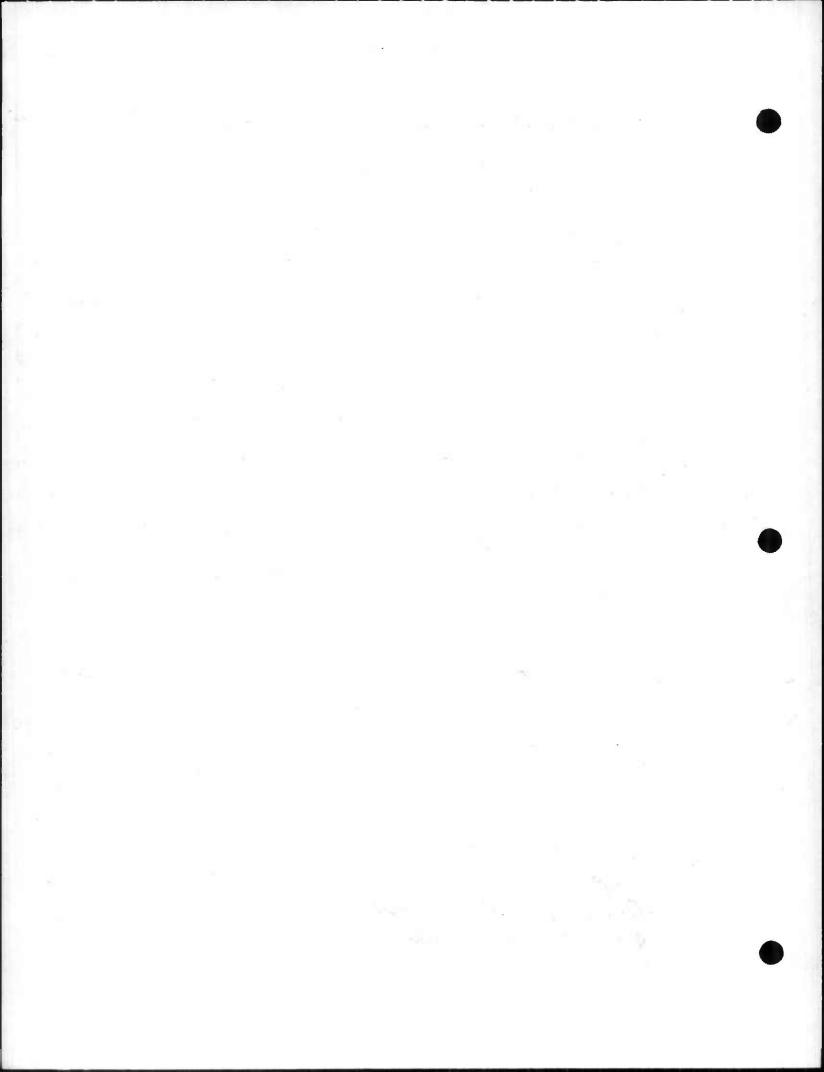


	_	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL	HYGIENE REG. NO.			
D		1. OECEDENT'S NAME (First, Middle, Last)	RODERT (30 Llin	100		2. DATE (1995	3. TIME OF DEATH	
9		4. SOCIAL SECURITY NUMBER 213 30 1080	1) M 2 □ F	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE C		Cou	THPLACE (State or Foreign ntry)	
2, 3 should	TOR.	PENINSULA REGIONAL MEDICAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY WICOMICO RESIDENCE OF DECEDENT									
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT		10c. CIT	Y, TOWN OR LOCAT	TION				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
ısıt	IERAL	100. STREET AND NUMBER	7 407 3	57	7	ZIP CODE		10g	. CITIZEN OF	WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER II FORCES? 1 YES IF YES, GIYE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuban, Maxico 2 NO Specia	n, Puerto R		Bla	CE — American Indian, ck, White, etc.	
	8	15. OECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)			USUAL OCCUPATION FOR JUNE 10 PROPERTY OF THE P		16b.	KINO OF BUSINES	S/INDUSTRY	31.15	
LAND 2- the hospital or detached for once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)	3485	SUPER	nozivs	18. MOTHER'S NA	ME (First, M	iddle, Maiden Suma	rme)		
MARYL retained by t 5 should be notified at		HARRY L. D. 19a. INFORMANT'S NAME (Type/Print)	roidrille	19b. MAILING	ADDRESS (Street a	GRACI	Route Number	S S S Nr. City or Town, Stein	(7) L	JURT 21843	
MORE, N e 6 may be re rector, page 5 must be no		20a, METHOD OF DISPOSITION OF Burlet 2 Cremetion 3 Rem	novat from State	D. PLACE AND DATE of the terry, cremetory or of	OF DISPOSITION (Na	Reson	OATE	20c. LOCATIO	CLAO	City No. Town, State	
BALTIMORE, MARYLAND st death. Page 6 may be retained by the hospita the funeral director, page 5 should be detached stall examiner must be notified at once.		4 Donation 5 Other (Specify) 21. SIGNATORE OF FUNERAL SERVICE LI		ARKWOO	22. NAME AN	NO ADDRESS OF FA	CIUTY	T TARK	rilli	1 ARYLAND	
F 5 E		23. PART i. Enter the disesses, or	complications that deuse List only one cause on a	d the death. Do n	8800 not enter the mo	O HARF	h as cerdi	ROPO '	y arrest,	Approximets	
d within 24 hours ompletely filled in the cremation, or re-		IMMEDIATE CAUSE (Final disesse or condition resulting in death)	· Inlevie		ocard	lial (mf	orch	con	Interval Between Onset and Death	
X 68 e execute an and c to buria	TION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS A	CONSEQUENCE OF	7:						
P.O. BO th certificate b ending physici Hygiene prior or other tra	RTIFIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	7):						
DS, I the deat the atte d Mental	AL CE	PART II. Other significant condition	ns contributing to death b	out not resulting i	n the underlying	g cause given in	Part I.	24a. WAS AN AUTO PERFORMED!		b. WERE AUTOPSY FINDINGS	
signed Health Ws. an	MEDICAL							1 TES TO N		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
TAL The law are has b are Depr.	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	28. PLACE OF OEAT		UNCERTAI	N 🔲				
CLA!	PHYS	1 YES 2 NO 27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	4 Nursing Hom	e 5 Rasidence URY AT RK?		(Specify) CRIBE HOW INJURY	Y OCCURED		
After death	ED BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be datarmined	28e. PLACE OF INJURY building, etc. (Spec	' — At home, farm, a		YES 2 NO	28f. LOCA City o	TION (Street and Nur Town, State)	imber or Rural	Route Number,	
AL OR	COMPLETE	29a. CERTIFIER (Check only CERTIFYING PHYSI	tCIAN: To the best of my know								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	ш	29b. SHINATURE AND TITLE OF CERTIFIES	R: On the basis of examination	n and/or investigation	n, in my opinion, d	eath occured at the 29c. LICENSE NUI				(a) and menner as stated. O (Morth, Day, Year)	
E E E E E E E E E E E E E E E E E E E	TO B	30, HAME AND ADDRESS OF PERSON WIS	O COMPLETED CAUSE OF DE	ATH TITEM 27) (Type,	Print)	D307	3	•	5/16	195	
15		31. DATE FILED (Month, Day, Year)	L. THEREN	LOCUST	Streets	SALis	buny	md, à	21801		



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	3
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	HEALTH AND M	MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last)	Estalle K				2. DATE OF DEATH	2 195	3. TIME OF DEATH 5 10: 40 M		
29		4. SOCIAL SECURITY NUMBER 216-01-2624	1 □ M 2 🎇 F	(In yrs. lest birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. 0	BIRTHPLACE (State or Foreign Country)		
2, 3 should	стоя	99. FACILITY NAME (# not institution, give so Howard County Ger RESIDENCE OF DECEDENT		al		or Location of OE	ATH	9c. COUNTY HOW	of DEATH Jard		
L. Pages 1,	DIREC	10a. STATE 10b. COUNTY MD HOWAI		10c. CrT	Columbi				10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
nsk permit.	ERAL	100. STREET AND NUMBER 5400 Vantage Point	Road #510		101	21044		10g. CITIZEN	OF WHAT COUNTRY?		
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, ap			-	RACE — American Indian, Black, White, atc. Specify: White		
D 21 spital or ed for u	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5 +)	Ille. Do NOT us	rork done during mo e retired.)	est of working	n Smithson				
be del	BE COMPI	17. FATHER'S NAME (First, Middle, Last) Thomas Kane	110110				E (First, Middle, Melden Manning	Surname)			
MA e retain e 5 shot notifie	70		nughter)				Columbia, City or Tow		1046		
MOH le 6 m rector.		20a, METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	Fo:	PLACE AND DATE Of the lettery, cremetory or other Linco	ln Cem.	May 25,	1995 Blac	densbur			
SAL r death r death al.		Leroy M & Russell C Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045									
within 24 hours spletely filled in cremation, or re rent, the med		23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one cause on ea	ech line.	1,29				Interval Between Onset and Death		
H.O. BOX 68 th certificate be execute ending physician and or I Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	Kuch.	e Du	lysalay	des	neso Geno		
signed by the Health and M	MEDICAL (PART II. Other eignificant condition			g causa given in F	Part I. 24s. WAS AN PERFOR	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
The law ite has b ate Dept.	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE] UNCERTAIN					
PHYSICIAN this certifi with the	BY PHYSI	1 YES 2 AND 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1 Impatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	atient 3 DOA 29b. TIME	4 Nursing Hom OF 28c, INJ JRY WO	URY AT RK?	Other (Specify) 28d. DE\$CRIBE HOW I	NJURY OCCUR	ED		
TTENDI TOR: A after de	ETED B	3 Suicide 8 Could not be 4 Hornicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, s	treet, factory, offic	•	281. LOCATION (Street I City or Town, State)		tural Route Number,		
로 로 본 =	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION OF THE CHAPTER O	CIAN: To the best of my knowl 3: On the bests of examination	adga, death occurre	d at the time, data n, in my opinion, d	and place, and due t	o the cause(s) and mar ims, data and place, en	nner as stated.	use(a) and manner sa stated.		
TO THE HOSPI TO THE FUNES be filed within	TO BE	29b. SIGNATURE AND PRESENTIFIER				0-22			GNED (Month, Day, Year) 4 22,1995		
20		30. NAME AND ADDRESS OF PERSON WHO J. J. L. E. V. S. B. 31. DATE FILED (Month, Day, Year)	SCOMPLETED CAUSE OF DE	Liffe	PARIX	cis Als	Colema	me, me	y 22,1995- w 2044.		
		MAY 2 4 1995	Jana d'invelsor	Rendell							

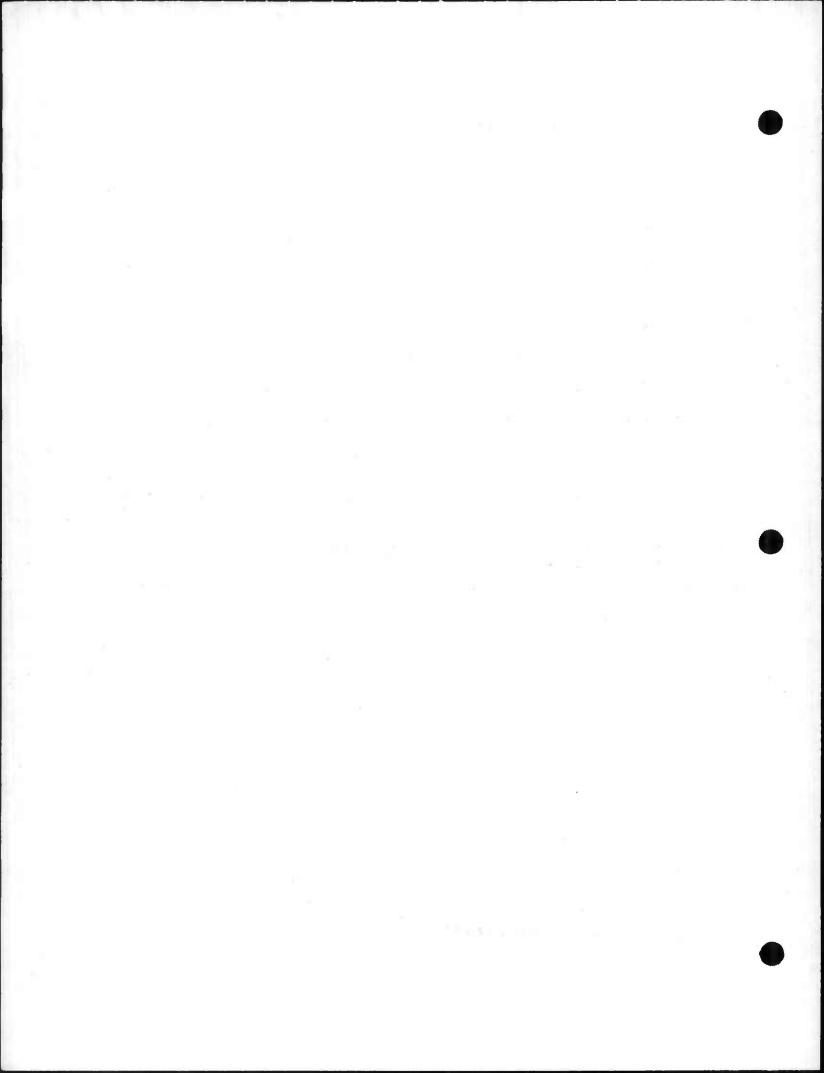


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

		REGISTRAR		CERTIFIC	CATE OF DEATH	REG. NO.						
		1. DECEDENT'S NAME (First, Middle, Last) George	I. Bowen, S	n		2. DATE OF DEATH MONTH DA	1995 YEAR	3. TIME OF DEATH				
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yr.		F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		PLACE (State or Foreign				
		213-36-5639	1 ≥ M 2 □ F 57	YRS.	ONTHS DAYS HOURS MIN.	Nov 23.1	937 Man					
Should	_	9e. FACILITY NAME (If not institution, give str		9	b. CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF DE	ATH .				
2,	DIRECTOR	1800 Wendover	<u>Rd.</u>		Baltimore		Balti	more				
iges 1,	띪	10a. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCATION			10d. INSIDE CITY				
2			altimore		Baltimore			1 YES 2 NO				
t perm	ERAL	10e. STREET AND NUMBER	0.1		10f. ZIP CODE		10g. CITIZEN OF W					
burial-transit permit. Pages	INE	1800 Wendove	R Rd.	AMARIE	21234		<u>u.s</u>					
burial	FUN	1 Never Married 2 Married	FORCES? 1 YES 2	NO	13. WAS DECENDENT OF HISPAI If yee, specify Cuben, Mexica	in, Puerto Rican, etc.)	Black,	- American Indian, White, etc.				
as the	D BY	3 Widowed 4 Divorced	TES, GIVE THAT ON DATES		1 YES 2 NO Specif	y:	Specify	White				
nse a	l III	15. DECEDENT'S EDUC. (Specify only highest grade of		(Give kind of world	SUAL OCCUPATION k done during most of working	16b. KIND OF BUS	INESS/INDUSTRY					
ě	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	IIIe. Do NOT use n	1227	C/.	11 1					
detached once.	COMP	17. FATHER'S NAME (First, Middle, Lest)	IV / TI	I RON V	Vorker 18. MOTHER'S NA	Ship	Yard					
ಕ ಕ	ш	William C. Box	wen			hy Parks	oomerney					
5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)			ODRESS (Street end Number or Rural	Route Number, City or Town						
page 5	-	Mrs. Rhona A. I	Bowen	1800 l	Vendover Rd.	Balto., M	d. 2123	4				
		20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremetion 3 □ Remon 4 □ Donation 5 □ Other (Specify)	val from State 20b. PLA	CEAND DATE OF I	DISPOSITION (Name of	DATE 29c. LOC	CATION — City or Tow	rn, State				
		21. SIGNATURE OF FUNERAL SERVICE LICE	:NSEE	laney	Place) Calley Cem. 22. NAME AND ADDRESS OF FA	CILITY						
e funeral di I. examiner		Hartley Miller Funeral Home										
	Н	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
POE		anock, or neart failure. L	lat only one cause on each	line.	enter the mode of dying, suc	in an cardine or reapir	ratory arrest,	Approximate Interval Between				
cremation, o		IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										
completely ial, cremati event, t		resulting in death) a	DUE TO (OR AS A CO	SEQUENCE OF):	C 970C1 4			21-13				
and co burial	N	Sequentially list conditions, b.										
physician and one prior to buni	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
phys ne p	Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A COM	SEQUENCE OF):				1				
attending ntal Hygier y, or oth	ERT	reaulting in deeth) LAST										
the atte Mental	၂၀၂	PART II. Other algolificant conditions	contributing to deeth but n	Ot resulting in 1	the underlying cause given in	Part I. 24e. WAS AN /	ALITOPSY 24h	WERE AUTOPSY FINDINGS				
th and	DICAL	DM-2			,	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
5 0 00	MEC					1 1 163 2		OF DEATH? 1 YES 2 No				
as beer Dept. of 23 sh	ž	DID TOBACCO USE CONTR	BUTE TO CAUSE OF D	EATH YES	NO UNCERTAI	N D						
certificate has been sin the State Dept. of He 1, or item 23 shown	ICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. P	LACE OF DEATH	Check only one)							
the Si	G I		1 Inpatient 2 ER/Oulpatien	t 3 🗆 DOA 4	☐ Nursing Home S Residence							
fter this c eath with marked,	уну.	1. Natural 5 Pending	(Month, Day, Year)	28b. TIME O		28d. DESCRIBE HOW IN	JURY OCCURED					
: After of death	ВУ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY - A	I home, farm, stre		28f. LOCATION (Street at	nd Number or Rural Ro	ute Number				
after 28 I	ETED	4 Homicide 6 Could not be determined	building, etc. (Specify)			City or Town, Stete)						
DIRECT HOURS	PLE	29e. CERTIFIER Check only	AN: To the best of my knowledge	, death occurred a	it the time, date end place, end due	to the cause(s) end many	ner as stated.					
THE FUNERAL DIRECTOR: After this fled within 72 hours after death with PORTANT: If Item 28 Is market	COMPL				n my opinion, death occured at the			and manner es stated.				
THE FUNE filed within PORTANT:	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	~		29c. LICENSE NUN		29d. DATE SIGNED (Month, Day, Year)				
De de la maria	TO B	17 8	Jame -	~	10 Bg / Hi	673	15/53	25				
λ		30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pri	MA BIL		1					
\bigcirc		31. DATE FILED (Month_Day_Year)	5810 Py	14/12	10 179 1871	not mo	212	90				
		MAY 2 4 1995 July	dendrich de de de					100				
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

1. DECEDEN	IT'S NAME (First,	Middle, Last)			BC	ONE					May 2	3 199	YEAR	3. TIME OF DEATH
100	-20-89		5. SEX 1 XM 2 F	6. AGE (In y	rs. lest birthde	MONTHS	DAYS	IF UNDER	MIN.	(Mo	TE OF BIRTH orth, Day, Year)		8. BIRT Coun	
9e. FACILIT	Y NAME (If not in	stitution, give s	treet end number)			96. CIT		OR LOCATI		EATN			INTY OF	Virginia DEATN
H	INT JOSE		ical Center				Tow	rson,	Man	/lanc	f	E	3altin	enor
10a. STATE	ACE OF DEC	10b. COUNT	1		10c.	ATY, TOWN	OR LOCAT	TION						10d. INSIDE CITY
Mary		Har	ford			Fa1	1st	on						LIMITS? 1 YES 2 NO
	tand number 5 Harf	ord 1	Dood				100	ZIP COD				10g. CIT		WHAT COUNTRY?
ti. MARITAL		. OI a		IT_EVER IN U.	S. ARMED	13.		2104		HIC OBI	SIN? (Specify Ye	or No	USA	
10	Married 2 X		12. WAS DECEDEN FORCES? IF YES, GIVE Y	YES 2	2 □NO S	"	If yes, sp	ecify Cube	in, Mexica	in, Puerl	o Rican, atc.)	0 NO -	Blac	E — American Indian, k, White, atc.
3 41004		EDENT'S EDU		V, II									1 2 3	White
Elements	(Specify only ary/Secondary (0	highest grade	completed) College (1-4 or 5		(Give kind life. Do NO	of work done use retired.)	during mo	on ast of workli	ng	1	6b. KINO OF BU	SINESS/IN	DUSTRY	
1	2	.2,	Consider (1-4 of 5		Stee	Lwor	cer				Beth-S	Stee	1	
	S NAME (First, Mi										t, Middle, Maiden			
	n J.				Tens Man	NO ADDDES	0.00		_		M. Rez			
	Boon										imber, City or Tow 1ston			147
20a, METNO	D OF OISPOSITI	ON 3 Rom	numl from State	20b.PL	ACE AND DAT	E OF DISPO	SITION/Na				-			
4 Donati	on 5 🗆 Other	20b. PLACE AND DATE Of DISPOSITION OATE										, Md		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk													
21. SIGNATU	RE OF FUNERAL	. SERVICE LIC	ENSEE	/	1	22.	NAME AN	D ADDRE	SS OF FA	CILITY				Dunda1k
10	Intho	w. C	St G	nno l	ly	22.	NAME AND Conn	ell	SS OF FA	ine	ral Ho	ome	of 1	222
23. PART	L. Enter the di shock, or he E CAUSE (Fin r condition	nomina, or condition	CF Complications the List only one cet	Me to coused the se on each	death. D	22. (NAME AND CONN	E SO	ss of FAM Y Fu 11e1 Ing. auci	INE	ral Ho Point	ome	of 1	
23. PART I	L Enter the dishock, or he E CAUSE (Fin r condition in death)	ons, liste	end one cetter of the control of the	Mod t ceused the	METAS DINSEQUENCE	OF):	NAME AND CONN	E SO	ss of FAM Y Fu 11e1 Ing. auci	INE	ral Ho Point	ome	of 1	Approximate interval Betwee Onset and Dec
23. PART II. O	L Enter the dishock or he E CAUSE (Fin r condition in death) Illy list condition in death)	ons, liste on the condition	end one cetter of the control of the	t coused the coused th	METAS WITH THE THE THE THE THE THE THE THE THE T	22. () TATIC OF): OF):	7110 r the mo	SO de of dy	ss of FAA Y Fu 11er Ing. auci	CS has co	ral Ho Point Irdiac or reap IOMA 24a. WAS AN PERFOR	DME Rd Iratory ar	of 1	Approximate interval Betwee Onset and Dei 6 YEARS WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
23. PART I IMMEDIAT disease or resulting i Sequentie if any, lear cause. Eni CAUSE (Di that Initiat reaulting i PART II. O CHI SEL	L Enter the dishock, or he E CAUSE (Fin r condition in death) Illy list condition in death)	ons, liste NG Py Tax Condition RENAL	OUE TO	t coused the rise on each COR AS A CO COR AS A CO COR AS A CO COR AS A CO	METAS PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE	OF):	NAME AND CONN 7110 r the mo	SO do of dy	ss of FAA Y Fu 11er Ing. auci	Ine CS h as co	ral Ho Point Irdiac or reap IOMA 24a. WAS AN PERFOR	AUTOPSY MAED?	of 1	Approximate Interval Betwee Onset and Dei G YEARS WERE AUTOPSY FINDING AMAILABLE PRIOR OF CAUSE
23. PART II IMMEDIAT disease or resulting if sany, lear cause. Enit CAUSE (D) that initiat resulting if the cause in the c	L Enter the dishock, or he E CAUSE (Fin r condition in death) Illy liet condition in death)	ons, liste NG y	END S OUE TO C. OUE	t coused the reconstruction of the reconstru	METAS PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE PASEOUENCE	22. (C) (C) (C) (C) (C) (C) (C) (C) (C) (C)	7110 r the mo	SO do of dy	ss of FAM Y FU 11er ing, auci	Ine CS h as co	ral Ho Point Irdiac or reap IOMA 24a. WAS AN PERFOR	AUTOPSY MAED?	of 1	Approximate interval Betwee Onset and Dei 6 YEARS WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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23. PART II. O CHI SE'. DID TO 25. WAS CAS EXAMINI: t Yes 27. MANNER	Lenter the dishock or he E CAUSE (Fin rondition in death) Illy list condition in death) Ill	ons, liste on dition on the condition of	END STOUE TO CARD STATE OF THE PLANE OF THE	t coused the rese on each rage in the research to the research	METAS WETAS WITH THE TABLE OF	OF): OF):	nderlying PRO PRO PRO PRO PRO PRO PRO PRO PRO PRO	SO de of dy STAT	SS OF FAI Y FU 11er Ing. auct E CAI	Pert I.	Point rdiec or reap VOMA 24e. WAS AN PERFOI 1 YES 2	AUTOPSY MED?	Of] 212 reat,	Approximate interval Betwee Onset and Del G YEARS WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 XNO
IMMEDIAT disease or resulting if any, lear cause. Eni CAUSE (Dithat Initiate resulting if any, lear cause. Eni CAUSE (Dithat Initiate resulting if any, lear cause. Eni CAUSE) PART II. O LIP SEV DID TC 25. WAS CAS EXAMINITE 1 Nature 2 Accid and any learning if a	L Enter the dishock or he ECAUSE (Fin r condition in death) Illy list condition in death) I	ons, liste NG Ly Londing Internal Could not be stermined Set Lexamined	CIAN: To the best of eg.	t coused the see on each rage in the see on each rage	METAS WETAS WETAS WISSOUENCE WISSOUENC	22. (C) D not enter TATIC OF): OF): OF): OF): ATN (Check A Number of Number o	NAME AND CONTY THE MODEL OF THE	SO de of dy STAT	ss of FAM Y FU 11er ing, auci ECA	Pert I.	POINT POINT	AUTOPSY AMED? NO NJURY OCCURRED STATES AND NUMBER AS SEEN AS	Of] 212 reat, 248 CUREO	Approximate interval Betwee Onset and Del G YEARS WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 XNO

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HO	TO THE FU be filed with	IMPORTA

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPA	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	BADNEC		2. DATE OF DEATH DAY	YEAR 3. TIME OF DEATN							
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		95 3:03 PM 8. BIRTNPLACE (State or Foreign							
	247-22-3240	1 □ M 2 □ F 71 YRS.	MONTHS DAYS HOURS MIN.	(Month, Dey, Year) 05-05-24	4 S.Carolina							
R	90. FACILITY NAME (II not institution, give street University Hosp		96. CITY, TOWN OR LOCATION OF Baltimore	DEATN	Sc. COUNTY OF DEATH Baltimore							
CTC	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			2								
BY FUNERAL DIRECTOR		timore	TY, TOWN OR LOCATION PIKESVILL	0	10d. INSIDE CITY LIMITS? 1 YES 2 NO							
AL	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
NER	6615 Baythorne		21209		U.S.							
/ FU	1 Never Married 2 Merried	2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1, YES 2 NO IF YES, DIVE WAN OR DATES	13. WAS DECENDENT OF HISP If yes, specify Cuben, Mexi 1 YES 2 JNO Spe	cen, Puerto Rican, etc.)	TNO— 14. RACE — American Indian, Black, White, etc. Specify:							
	3 🔀 Widowed 4 🗌 Divorced 15. OECEDENT'S EDUCAT	Army			Black							
COMPLETED	(Specify only highest grade co.	(Give kind of life, Do NOT is		16b. KINO OF BUSIN								
MPL	12th	0 Nursi	ng Assistant		oward V.Admin.							
	17. FATHER'S NAME (First, Middle, Last) Ephran Barnes		16. MOTHER'S I	NAME (First, Middle, Meiden Su Le Brown	imame)							
TO BE	190. INFORMANT'S NAME (Type/Print) Edith Barnes	19b. MAILIN	O ADDRESS (Street and Number or Run	al Route Number, City or Town,	State, Zip Code)							
	20a, METHOD OF DISPOSITION		Baythorne Ro	1111311	lle, MD. 21209							
	1 Buriel 2 Cremation 3 References 4 Donation 6 Other (Specify)	al from State cemetery, crematory or	of Disposition (Name of other place) [emorial Cem.		narleston, S.C.							
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	22. NAME AND ADDRESS OF	1721-27 N.Monroe St.								
	Nouth	Heeth CFSP #28		S F/H	co., MD. 21217							
	shock, or heart feilure. Lis	nplications that caused the deeth. Do at only one cause on each line.	not enter the mode of dying, so	ich as cerdiec or respira	intervai Between							
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Proumon			Onset and Death							
- 1	recording in deatily	DUE TO (OR AS A CONSEQUENCE C	OF):		10 dua							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE O	PF):									
S	CAUSE (Disease or Injury	cause. Enter UNDERLYING CAUSE. (Disease or Injury										
E	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE O)r):									
	PART II. Other algorificant conditions of	contributing to death but not resulting	in the underlying cause given i	n Part i. 24s, WAS AN AU	JTOPSY 24b, WERE AUTOPSY FINDINGS							
MEDICAL		reuse diseas	e	PERFORMI	ED2 AVAILABLE PRIOR TO COMPLETION OF CAUSE							
	Concestive	1000	ue		OF DEATH?							
AN	DID TOBACCO USE CONTRIE		ES NO UNCERTA	IN 🗆								
PHYSICIAN:	EXAMINERS 1 YES 2 NO	OSPITAL: Supportiont 2 = ER/Outpettent 3 = DOA	OTHER: 4 □ Nursing Home 5 □ Residence	e 6 ☐ Other (Specify)								
	27, MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year) 28b. TII	JURY WORK?	28d. DEŞCRIBE HOW INJI	URY OCCURED							
) BY	2 Accident Investigation 3 Suicide 8 Could not be	26e. PLACE OF INJURY — At home, ferm,	M 1 YES 2 NO	281. LOCATION (Street and Number or Rural Route Number,								
E	4 Homicide determined	building, etc. (Specify)		City or Town, State)								
COMPLETED		N: To the best of my knowledge, death occur										
- 11	29b. SIGNATURE AND THILE OF CERTIFIER	On the basis of examination end/or investigati		CILIDAS .								
O BE	Merce	er MD	29c. LICENSE N	766	19d. DATE SIGNED (Month, Dey. Year)							
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH (ITEM 27) (Type	IV. OF MARYZA	MD 22 0	GRACILE OT							
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	BATM	OKE, MOS	21201							
	MAY 2 4 1995 Ali	Dhuster Karlell										

6 may be retained by the hospital or attending physician. **ORE, MARYLAND** 21215-0020

notified at once.

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permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH
MONTH
MRY 3. TIME OF DEATH Edward John 9:50 1995 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. HOUME 1 X M 2 F 83 YRS. 169-01-1356 912 Penna February Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MATON MEMORIA Hospita DIRECTOR Himore N/A 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Penna. Butler Mars 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 416 Lincoln Ave 16046 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yee, specify Cuben, Maxican, Puerto Ricen, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Merried Specify: White BY 3 Widowed 4 Divorced ETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Dentist 5+Self Employeed 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Crawford Campbell BE Ida Ekas 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 John E. Campbell. Pa. 17404 <u>RD 6 Sunset Lane - York ,</u> 20s. METHOD OF DISPOSITION 1 X Burlel 2 Cramation 3 C 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Memorial Pk. 5/26/95 McCandless Twp. Leonard J. Ruck Funeral Home, Inc. Uonala 5305 Harford Rd. Balto. Md. 21214 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lief only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Acute Renal Failure 5 days reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): tungal Sepsis 2 weeks CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate Ventilator Dependent cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events 2 weeks DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST Resp. Fallure 1 month PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE Colon Camer 1 - YES 2 NO OF DEATH? Dementia 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🕱 NO 🗆 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 propertient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 THO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY 2 Accident
3 Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE



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MAY 2 4 1995

MID.

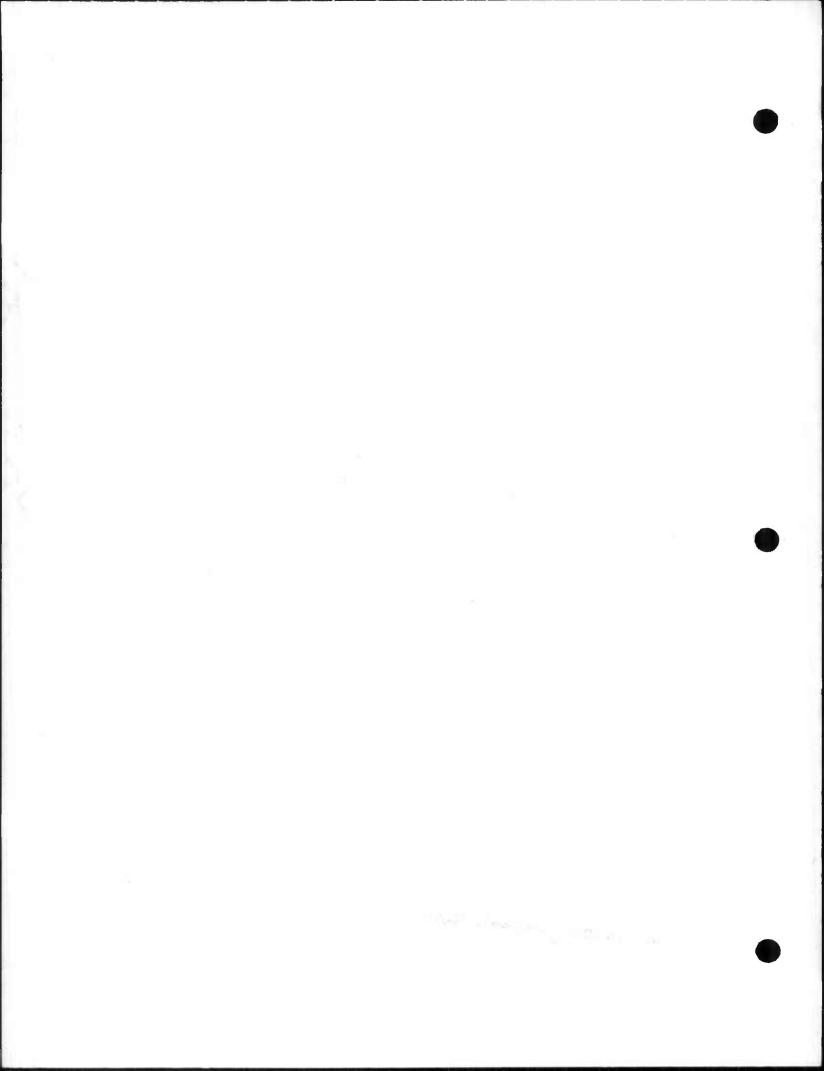
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Kesident

May 21, 1995

UMH- 0046

M.D. UMHO FOLE E. Clear. PKWy, Baltimore, MD 21218



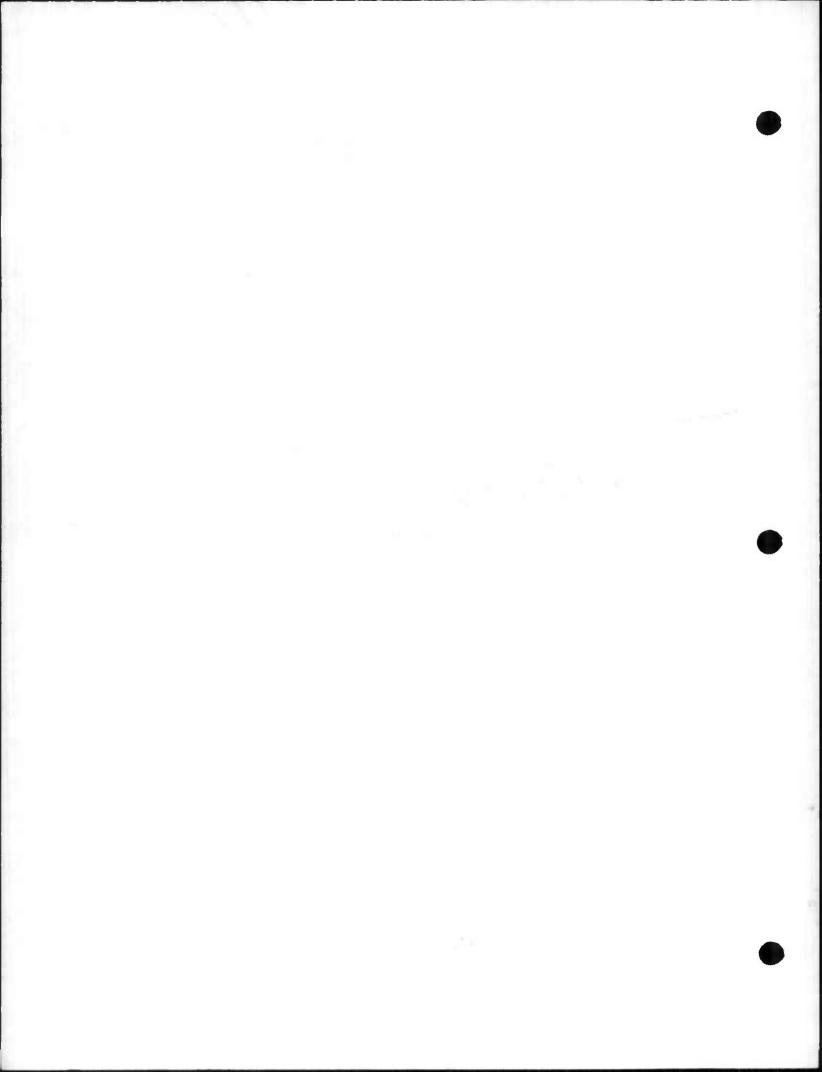
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should dead within the State Degr. of Health and Mental Hyghers prior to burial, corrented. The following a funeral page of the property or mental and the property or mental and the property or mental and the property or mental and the property or mental and the property or mental and the property or the property or mental and the property or mental and the property or mental and the property or mental and the property or the property or mental and the property or mental and the property or the propert	HOLL CO IS HIGHER
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First				-				2. DATE OF 0			3. TIME OF DEATH						
		Da	4				MONTH DAY 19 1995 3			520 A.M								
				6. AGE (In yrs.	n yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				7. DATE OF BIRTH 8. BIRTHPLACE (State or F			HPLACE (State or Foreign						
	577-03-5665 1 🗆 M 2 📐 F			87	YRS.	MONTHS	DAYS	HOURS MIN.	MAY 1,		Coun	JTH CAROLINA						
	9a. FACILITY NAME (If not in	stitution, give str	eet and number)			9b. CITY, 1	OWN C	OR LOCATION OF OR			COUNTY OF	DEATH						
OR	LAUREL REGIONA	L HOSPIT	AL					LAUREL			PRIN	CE GEORGE						
اظ	RESIDENCE OF DEC	10b. COUNTY			1													
DIRECTOR					10c. CI1	Y, TOWN OR	LOCAT					10d. INSIDE CITY LIMITS?						
	MARYLAND	PRI	NCE GEORGE				_	BLADENSBUR	RG			XX YES 2 NO						
RA	3801 KENILWORTI	H AVENUE					101	20710		100	USA	WHAT COUNTRY?						
FUNERAL	11. MARITAL STATUS	AVENOL		~ = 1.00			\perp											
	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W			14	yes, sp	ENDENT OF HISPAN solfy Cuban, Maxica	n, Puerto Rican		Blac	CE — American Indian, ck, White, atc.						
BY	3 📉 Widowed 4 🗌 Divo	roed	IF YES, GIVE W	MR OR DATES		1 [YES	2 XXNO Specify			Spe	offy: WHITE						
COMPLETED	15. DEC	EDENT'S EDUC	ATION	18a.	DECEDENT'S	USUAL OCC	UPATIO	ON	18b, KIN	D OF BUSINES	S/INDUSTRY							
4	Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life, Do NOT u	work gone au se retired.)	nng mo	st of working										
P P	UNAVAILABLE		UNAV.		E	KAMINER			U	S GOVERN	MENT							
8	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOTHER'S NA	ME (First, Middle	, Maiden Surne	me)							
BE	ANTHONY NOLAN I							MARY (UNAVAIL	ABLE)								
2	19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILING	ADDRESS (Street a	nd Number or Rural F	loute Number, C	ity or Town, Sta	te, Zip Code)							
- 1	ANITA CURRENCE				RT 1,	30X 62	Α, Η	HUTTONSVILL	E, WEST	VIRGINI	A 26	5273						
	20a. METHOD OF DISPOSITI	n 3 🗆 Remo	val from Stata	cemetery,	CEAND DATE	ther place)			DATE	20c. LOCATIO	N — City or T	own, State						
	4 Donation 5 Other 21. SIGNATURE OF FUNERAL			BALTI	MORE W			CREMATORY	5/21	LAURE	L, MARY	'LAND						
	21. SIGNATURE OF FUNERAL	O'SENVICE CHE	NSKE (0				D ADDRESS OF FAC	FL	ECK FUNE	RAL HOM	E, INC.						
	/	al on ll	Dub	aller				SANDY SPRIN				ND 20707						
	23. PART I. Enter the di	seesea, or co	ist only one cau	roused the	death. Do	not enter ti	ne mo	de of dying, auci	aa cardiac	or reapirator	y arreat,	Approximate						
	IMMEDIATE CAUSE (Fin		(4	and	1							Interval Between Onset and Death						
- 1	disease or condition resulting in deeth)	→ .	VA	Spid	acti	an	1	PUROV	wou	ia								
			DUE TO								1							
N	Sequentially list conditi	ona. b.		Cere	Gro		as	scula	LA	CCIC	Jen							
Ĕ	if any, leading to immed cause. Enter UNDERLYi	diate	DUE TO	(OR AS A CON	SEQUENCE O	F):												
CERTIFICATION	CAUSE (Disease or inju		DUE TO	(OR AS A CONS	SEQUENCE O	D: 1												
E	resulting in death) LAS	T - 31		D	Olis	POLIC	ef	ion										
S		d.									1 1							
MEDICAL	PART II. Other aignifice	nt conditions	contributing to	deeth but no	t resulting	in the und	erlylng	ceuse given in	Part I. 24a.	WAS AN AUTO		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
음									10	YES 2 N		COMPLETION OF CAUSE OF DEATH?						
ME												1 TES 2 NO						
ä	DID TOBACCO U		IBUTE TO CA					UNCERTAIN										
S	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PL	ACE OF DEA	TH (Check on OTHER:	y one)											
PHYSICIAN:	1 TYES 2 NO		1 npatient 2		_	4 - Nursin	g Hom	5 Raaldenca	6 Other (Spe	ocify)								
		Pending	26a. DATE OF (Month, D.	INJURY	26b. TIM	E OF 2	WO		28d. DESCRIE	E HOW INJUR	OCCURED							
B	2 Accident	investigation	28a PLACE O	F INJURY At	home from			ES 2 NO										
	3 Suicida 6 4 Homicide	nome, tarm,	atreet, ractor	y, onici		City or To	N (Street and No vn, State)	imber or Rural	Route Number,									
9	29a. CERTIFIER																	
	1 BUTCERT				don't accom	ed at the tim	e, data	and place, and due			a stated.							
MP			IAN: To the best of					one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.										
COMPLET	one) 2 MEDr	CAL EXAMINER								placa, and dua	to the cause(s) and manner as stated.						
		CAL EXAMINER						29c. LICENSE NUM				b) and manner as stated. D (Month, Day, Year)						
H	29b. SIGNATURE AND TITLE	OF CERTIFIER	Saula	ramination and/	or Investigation	on, in my opi												
	one) 2 MEDr	OF CERTIFIER	Sauce COMPLETED CAUS	SE OF DEATH (I	or Investigation	on, in my opi	nion, de	D 20										
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER F PERSON WHO S SH	Saula COMPLETED CAUS AHT 73	SE OF DEATH (I	TEM 27) (Type	on, in my opi	nion, de	D 20			DATE SIGNE							



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BALTIMORE, MARYLAND 21215-0020	ir death. Page 6 may be retained by the hospital or attending physician.	he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should al.	i examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)			\				E OF DEATH			TIME OF O	ATH
	Donald	0 1-	F Diacont				Ma		95	EAR	3:30	P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 YE			E OF BIRTH nth, Day, Year)	0.	BIRTHPL	VCE (State of	Foreign
1	219 18 8379	1 🔀 M 2 🗌 F	P.S	YRS.	MONTHS DA	/S HOURS MIN		0.7 19	37 1	Country)	LAno	
-	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY, TOV	VN OR LOCATION OF			9c. COUNTY	OF OEAT		
DIRECTOR	FRANKLIN JOVE	20th 3se	DITAL			JAOS2DAL:			Balt:	imore	2	
D D	10e. STATE 10b. COUNT	Υ		10c. CITY	, TOWN OR LO	CATION				10	d. INSIDE C	TY
1 1 1	MARYLAN BAI	Sonil			ADDI	Hall				12.7	LIMITS?	
AL	10e. STREET AND NUMBER				20.01	10f. ZIP CODE			10g. CITIZEN		-	
FUNERAL	1 THURDON	- Court	APT.	TT		283	_		1.	22.	1	
5	11. MARITAL STATUS	12. WAS DECEDER	T EVER IN U.S. AR	MED	13. WAS	DECENOENT OF HIS	PANIC ORIG	IN? (Specify Yes	or No — 14	RACE -	American in	dien,
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES	Ю		, specify Cuben, Mex YES 2 NO Spe		o Ricen, atc.)	Black, White, etc. Specify:			
	15. DECEOENT'S EDU	W-i								tw	ITE	
	(Specify only highest grade	e completed)	(Gi	ve kind of w Do NOT use	JSUAL OCCUP ork done during militard)	ATION most of working	19	Sb. KIND OF BU	SINESS/INDUS	TAY		
P	Elementary/Secondary (0-12)	College (1-4 or 5	") (Dark	1:005			المرسيا	2 malla	1251		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			1110	11120	18. MOTHER'S	NAME (First	Middle, Maiden	Sumame)	1121		
BE C	JoHn H- Die	1000	SR			THERS.	92	m 50	1:01-	SQ		
TO B	19e. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Str	et end Number or Rui	nl Route Nu	mber, City or Tow	n, State, Zip Co	de)	313	26
F	CAROLYN A. D.	TOOJA	1	THO	ans	VOS TO	TD	APT T	c P	RRY	HALL	3
	20e, METHOD OF DISPOSITION 10 Buriel 2 Cremetion 3 Rem	noval from State	20b. PLACE A		F DISPOSITION	(Neme of	S	TE 20c. LO	CATION — City	or Town,	State	
	4 Donation 8 Other (Specify)	A	PARK	MOON	270	ELERT	0	37 12	ARKIL	اخدا	PARYL	2.50
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. NAM	AND ADDRESS OF	FACILITY	Mino	الازع	1		
	Horse 40	1 mars			88	OO HARFO	RO R.	100 - 1	ARK.	110		
	23. PART I. Enter the diseases, or shock, or heert fellure.	complications the	t caused the de	eth. Do no	ot enter the	mode of dying, a	uch as ce	rdiac or reepi	retory arrest	,	Approxi	
	IMMEDIATE CAUSE (Final	List only one con	ree on each mie.									Batween nd Death
	disease or condition resulting in death)	. Adeno	carcinom	a of	lung o	complicat	ed by	chron	ic		1 ve	ar
1 1		DUE TO	OR AS A CONSECUTIVE P	UENCE OF	1:							
NO N	Sequentially list conditions,	b	(OR AS A CONSEC			Locase						
Į Į	if any, leading to immediate cause. Enter UNDERLYING	Dar 10	(OR AS A CONSEC	DENCE OF	N.							
	CAUSE (Disease or Injury thet initiated events	C DUE TO	(OR AS A CONSEC	UENCE OF)	:							
CERTIFICATION	resulting in death) LAST	d.										
1	PART II. Other eignificent condition	as contributing to	death but not re	andelma la	the underly	dee earlier object	G Dod I	T				
CAL		is contributing to	deeth but not re	southing in	i the under	ing ceuse given	in Part I.	24a. WAS AN PERFOR		AWA	RE AUTOPSY	A TO
MEDIC								1 ▼ YES 2	□ NO	OF	MPLETION OF DEATH?	CAUSE
Σ	DID TOBACCO USE CONT	DIRLITE TO CA	LICE OF DEAT	ru ve		- UNICEDIA	INI C			1 2	YES 2	NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUIE IO CA			(Check only o		III LI					
Sic	EXAMINER? 1 YES 2 X NO	HOSPITAL:	ER/Outpatient 3		OTHER:		6 7 6	202016				
H	27. MANNER OF DEATH	28a. OATE OF	INJURY	28b. TIME	OF 28c.	IOMe 5 Residenc		er (Specify) ESCRIBE HOW II	JURY OCCUR	FD		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, E	ay, Year)	INJU	AY	WORK? YES 2 NO				JONES		
	2 Accident 3 Suicide Could an				Number,							
TED	4 Homicide determined	Dullding atc (Specify)										
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the best of	my knowledge, dea	th occurred	at the time, o	ate end place, end d	ue to the co	euse(e) and men	ner as stated.			
o N	one) 2 MEDICAL EXAMINE	R: On the besis of e	namination end/or in	vestigation	, in my opinio	n, death occured at t	he time, dat	le and place, en	f due to the ca	use(e) end	f menner ee	stated.
	CONTROL AND THE CONTROL AND TH					29d. DATE SI						
O BE	Loward HBml mp D19793					3 > 5/18/95						
2	30. NAME AND ADDRESS OF PERSON WH									, ,		
	Howard Bond, M.D. 9618 Belair Road Baltimore, MD 21236											
	" MAY 2 4 1995	100 TESTON (110)	r Northelie									

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

95 15807 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR SAMUEL Α. MAY 22.1995 **EDWARDS** 14:00 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) #F UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign FEB. 9,1957 219-62-4321 MARYLAND 1X M 2 | F 38 9e. FACILITY NAME (If not institution, give atreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE n/a RESIDENCE OF DECEDENT 10b. COUNTY 10d. INSIDE CITY
V LIMITS?
YES 2 NO 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE n/a FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21218 UNITED STATES 532 Ε. 23 RD STREET 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XXYES 2 NO IF YES, GIVE WAR OR DATES ARMY 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: BY Specify: BLACK 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig entary/Secondary (0-12) College (1-4 or 5+) ARROW PARKING 12 TH ATTENDANT GARAGE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) SAMUEL S. **EDWARDS** JOSEPHINE WILLIAMS BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STREET, BALTIMORE, MARYLAND 21218 E. 23 RD JOSEPHINE **EDWARDS** 532 20a. METHOD OF DISPOSITION
1X_XBuriel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION — City or Town, State CROWNSVILLE VA CEMETERY 5-25 CROWNSVILLE, MD 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FU are WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata ahock, or heart fellure. List only one cause on each line. intarval Batwe Onset and Death IMMEDIATE CAUSE (Final disease or condition ____ thromboambolism. "Ulmonara DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 DYES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 XYES 2 NO 1 | Inpatient 2 ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 26e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be COMPLETED 4 Homicide detarmined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, end due to the ceuse(s) and manner es stated. 2X MEDICAL EXAMINER: On the basic of examination prid/or investigation, in my opinion, death occurred at the time, data end piace, and due to the cause(s) and menner as stated.

Fowler 111 Penn Street, Baltimore, Maryland 21201

OCME

29c. LICENSE NUMBER

Jelia d'Audion hardall

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29b. SIGNATURE AND TITLE OF CERTIFIED

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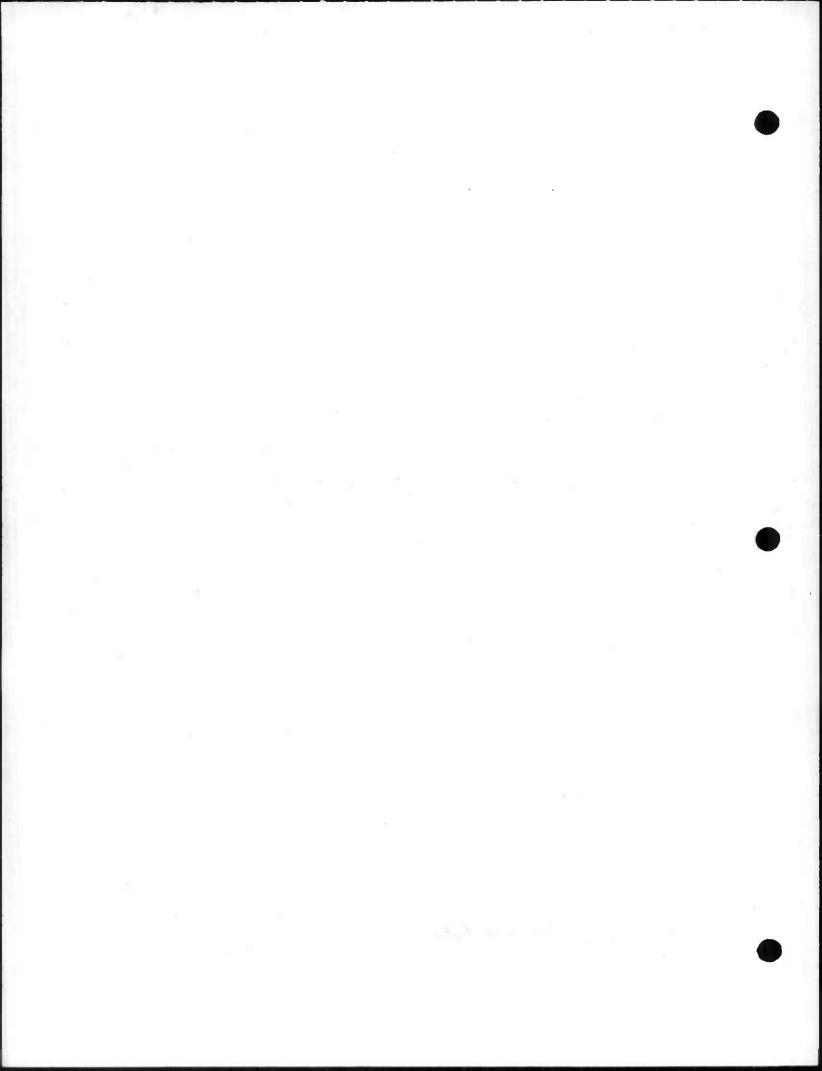
MAY 2 4 1995

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29d, DATE SIGNED (Month, Day, Year)

MAY 23, 1995



Pages 1, 2, 3 should

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e law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit part of Health and Merital Horison notor in burial commission, or named	
DO D	the th	
endi	55	
or at	nse	
Ital	10	
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MAY 19, 1995 8:26 WAYNE FRASER AM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign oct. 4, 1937 HOURS DAYS 1 M 2 - F 57 Washington, DC 579-50-7948 YRS. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Calvert Prince Frederick 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1265 Lottie Fowler Road 20678 USA 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO 14. RACE - American Indian, Black, White, etc. 2 7 10 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 TES 2 NO BΥ Specify: Specify: White 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) Landscape Designer Landscaping 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Ralph Earl Fraser Ida Mae Mitchell H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jacqueline M. Fraser 1265 Lottie Fowler Road, Prince Frederick, MD 20a. METHOD OF DISPOSITION

N☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Burlet 2 Cremation 3 H R 4 Donetton 5 Other (Specify) Washington National Cem. 5/23 Suitland, MD 21. SIGNATURE OF FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. Listionly one cause,on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ 6 reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY MEDICAL PERFORMED? YES 2 | NO DF DEATH? YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 X YES 2 NO Inpatient 2 XER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 284. DESCRIBE HOW INJURY OCCURED 95 1 Natural M BY 2 Accident Sulcide 28s PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) LOCATION /Str ED 6 Could not be 4 Homicide determined COMPLET 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occur 2 MEDICAL EXAMINER: eatigation, in my opinion, death occured at the time, data end place, end due to the cause(s) end manner es stated. ME AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE

THO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TO THE HOSPITAL (
TO THE FUNERAL D
BE filed within 72 h
IMPORTANT: If It

OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate ha hours after death with the State D

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C.M.E

111 Penn Street, Baltimore, Maryland 21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with character of the HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. LTIMORE, MARYLAND 21215-0020

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RECORDS, P.O. BOX 68760	cate he executed with
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	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH
	HAZEL MAXINE FARA						MAY D	22, 19	95 17:23 P. M
Ŗ	4. SOCIAL SECURITY NUMBER 217-22-7068	5. SEX 1 M 2 K F	6. AGE (In yrs. less	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	JAN. 12, 192	1.7	B. BIRTHPLACE (State or Foreign Country) KENTUCKY
ر م	9s. FACILITY NAME (If not institution, give	street and number)				OR LOCATION OF D	EATH		TY OF DEATH
5	SINAI HOSPITAL				BA	LTIMORE		BAL	TIMORE CITY
DIRECTOR	10a. STATE 10b. COUNT	LTIMORE C	ITY	10c. CIT	Y, TOWN OR LOC BA	LTIMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
4	10e. STREET AND NUMBER				1	Of. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?
EH	6810 PARK HEIGHT:	S AVENUE	41			212	15		U.S.A.
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARI YES 2 NAR OR DATES	MED IO	II yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 X NO Speci	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) fy:	or No	14. RACE — American Indian, Black, White, etc. Specify: WHITE
<u>a</u>	15. DECEDENT'S EDI (Specify only highest grad	UCATION to completed	16a. DE	CEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BU	SINESS/INDU	
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S S	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S NA	AME (First, Middle, Meiden	Surname)	
BE C	IVAN WILLIAMS					BESSI	E CLARK		
5	194. INFORMANT'S NAME (Type/Print) MRS. CONCETTA HAI	RRISON					Route Number, City or Tow VENUE - BAI		
	20a, METHOD OF DISPOSITION 1 XBurlal 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	moval from State	20b. PLACE	AND DATE	OF DISPOSITION (OATE 20c. LO	CATION — C	ity or Town, State
	21. SIGNATURE OF FURERAL SERVICE L	CINDIEE	NEW C	AInc	22. NAME	AND ADDRESS OF F	ACILITY	TIMOR	(E
	V Louis En	X)			AL HOME INC		01000
H	23. PART i. Entar the diseases, or	complications tha	1 ceused tha de	ath. Do	14 L U /	WILKENS A	AVENUE - BA	LT LMU	ORE, MD 21229
	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition	. Liet only one cau	ise on each line).					interval Between Onset and Death
	resulting in death)	a. Courd DUE TO	OR AS A CONSEC	OUENCE O	Collaps				Minutes
Z	Sequentially list conditions,	b. CC - OC DUE TO							rimter
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING								5-10 ta
FIC	CAUSE (Diseese or injury thet initiated evants	c. Venta	(OR AS A CONSEC	DUENCE O	F):				minates
E	resulting in death) LAST	d. Corp	ury ar	tom	disesse	2			beers
I - II	PART II. Other aignificent condition		(Part i. 24s. WAS AN	AUTODEV	24b. WERE AUTOPSY FINDINGS
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KSI	1 YES 2 NO	1 - Inpatient 2			4 - Nursing Ho		6 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		26b. TIM	IURY Y	JURY AT ORK? YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCL	JRED
8	2 Accident Investigation 3 Suicide 8 Could not be determined	26a. PLACE O	F INJURY — At holetc. (Specify)	me, farm,	street, factory, of	ce	261. LOCATION (Street City or Town, Stete)		or Rural Route Number,
COMPLET							e to the cause(a) and man		d. ceuse(a) and manner as stilled.
	296. SIGNATURE AND TITLE DE SERTIFIE					29c. LICENSE NU		_	SIGNED (Month, Day, Year)
O BE	/-//	Yel	- mo	My)		D 401		1.05	5-123/85-
F	30. NAME AND ADDRESS OF PERSON W	HO COMPLETEO CAU!	SE OF DEATH (ITE	M 27) (Type	Print)				

50 Painters M. U.Rd Seate 6 Owing Mill MD 21117

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A. Cherch L. Perform May 19 50 Painter

31. DATE FILED (Monity Denoted 5)

July 32 TEMPORADO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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PITAL OR ATTEN	CTOR	s after	20 1
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	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT OF CERTIFICATE OI		ENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last	GLENN		2	DATE OF DEATH	1005	3. TIME OF DEATH		
	4. SOCIAL SECURITY NOMBER 210-70-2707 99. FACILITY NAME (If not Institution, give	5. SEX 6. AGE (In yrs. I	7 YRS. MONTHS DAYS	F UNDER 24 HRS. 7 HOURE MIN. OR LOCATION OF DEAT	DATE OF BIRTH Hondi, Day, Year	8. BIR	THPLACE (State or Foreign		
ECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	-L THANDR	10c. CITY, TOWN OR LOC	FILMORY	5	N/F	7		
BIG	100. STREET AND NUMBER	N/A	BALTI	ON PB	Leo	- CITIZEN OF	10d. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTRY?		
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B	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES	XNO If yes, s	pecify Guban, Mexican, I S 2 NO Specify:	Puerto Rican, etc.)	14. HA	CE — American Indian, ck, White, atc.		
LETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (9-12)		DECEDENT'S USUAL OCCUPAT (Give kind of work done during in the Do NOT use retired.)	ION nost of working	16b. KIND OF BUSINES	SS/INDUSTRY	ant.		
COMPL	17. FATHER'S HAME (First Allottin Last)	70./	10092 1851	18. MOTHER'S NAME	(First, Middle, Meides Symi	D- ///	ME		
TO BE	19a INFORMANT'S NAME (Symptrint)	NJ-UNI	18th MAILING ADDRESS (Street	and Namber or Flural Flour	e Mombiec City or Rown, Stu	eta, Zijo Calde)	11111		
	20. METHOD OF DISPOSITION 1 Buriel 2 Cremethy 2 Re	novel from State 20b. PLACE	E AND DATE OF DISPOSITION (provide -	DATE 26c LOCATE	DN — Olly sr 1	Town, State		
		21. SIGNATURE OF EDISERAL SERVICE LICENSEE 22. NAT AND ADDRESS OF PROPERTY FORMS VIA,							
	23. PART I. Frier the diseases, or heart failure immediate CAUSE (Final disease or condition	complications that caused the c. List only one cause on each lin	ne.				Approximate interval Betwee Onset and Dea		
	resulting in death)	DUE TO (OR AS A CONS	Α.				Monte		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSI	EQUENCE OF):	IRED IMMU	NO DEFICIE	vey Dis	EBSIE YEAR		
MEDICAL CE	PART II. Other algorificant condition HE MOPT	na contributing to death but not	t resulting in the underlying	ng cause given in Pai	1 i. 24e. WAS AN AUTO PERFORMED	?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AN: M	DID TOBACCO USE CON	RIBUTE TO CAUSE OF DE					1 YES 2 NO		
YSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpetient	ACE OF DEATH (Check only one 3 DOA 4 Nursing Ho	me 5 🗆 Rasidenca 6 🗆	Other (Specify)				
ВУ РНУ	27. MANNER OF DEATH Natural 5 Pending Natural Investigation	28a. DATE OF INJURY (Month, Day, Year)	INJURY W	JURY AT 28 ORK? YES 2 NO	d. DEŞCRIBE HOW INJUR	Y OCCURED			
ETED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY — At h building, atc. (Specify)	nome, term, street, factory, off	26	t. LOCATION (Street and N City or Town, State)	umber or Rural	Route Number,		
COMPLE		SICIAN: To the best of my knowledge, of ER: On the bests of examination and/or					(a) and menner as stated.		
TO BE C	SIGNATURE AND TITLE OF CERTIFIE	nthalcuma	MD	D425		1. DATE SIGNE	0 (Month, Day, Year)		
F	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEATH (IT) ANTHA-KUM		N. EUTAN	ST, SUIT	E 407	,MD2120		
	MAY 2 4 1995	22. REGISTRES SHAFURE							

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DIVISION OF VITAL RECORDS. P.O. BOX 68760

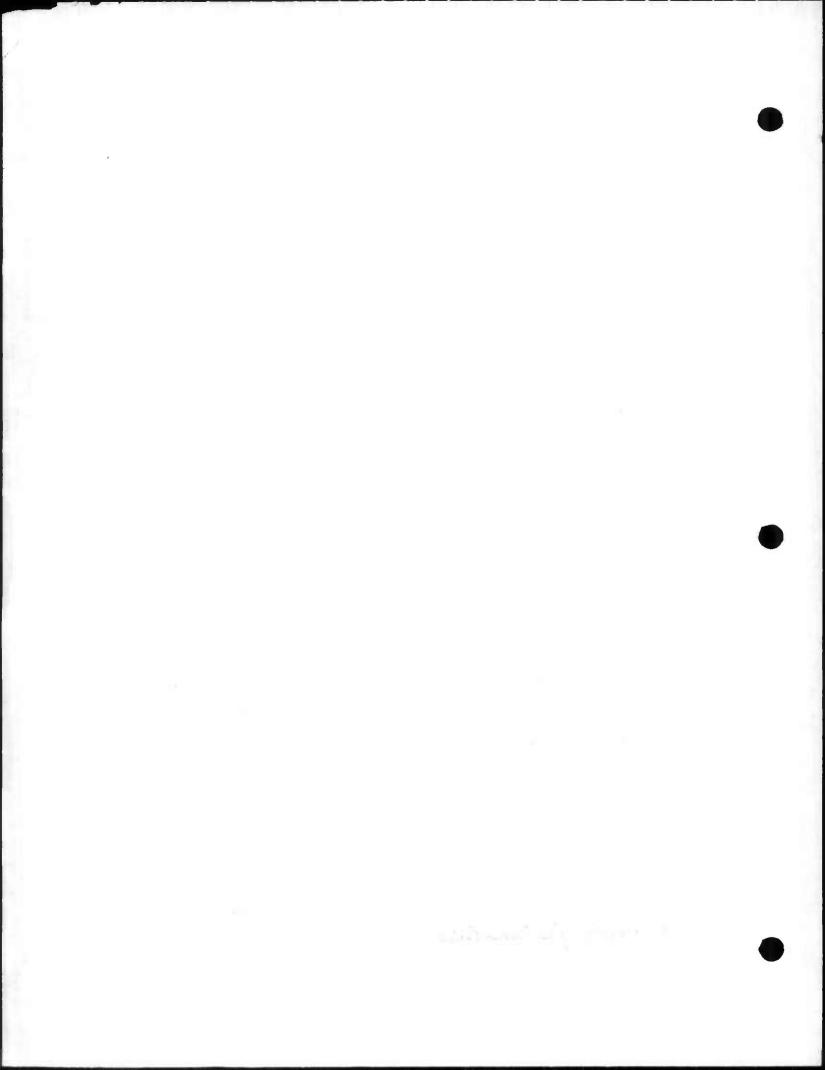
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	- 60 6				2. DATE OF DEATH		
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Page	DIRECTOR	MARYLAM			TOWN OR LOC				10d. INSIDE CITY LIMITS?
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the bur	ВУ	1 Never Married 2 Merried Widowed 4 Divorced	IF YES, GIVE WAR OR D			S 200 NO Specifi			pecify:
Se	ED E	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S I	USUAL OCCUPAT	TION	165 VINO OF BUIL	SINESS/INDUSTRY	311/160
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od be	BE	JOHN OCT	١			LSOE	WILT		
5 should notified	9	t9e. INFORMANT'S NAME (Type/Print)	1000	19b. MAILINO	A . 1 1	- 0	Route Number, City or Tow	n, State, Zip Code)	1 21271
bage bage		20e. METHOD OF DISPOSITION	LATIO	PLACE AND DATE O	CHED	DAK AV		CATION - City or	d 21234
director, pa		1 Buriel 2 Cremation 3 Remo	oval from State cen	netery, crematory or oth	her place)	SEMBIORY	5-33 BF	Winos	()
		21. SHOWING OF FUNERAL SERVICE LIC	ENSEE		22 NAME	AND ADDRESS OF FA	CILITY	2011110	ez l'ARVLADO
funeral di L examiner		1 / La 2	N /		SOM	SAHO EN	ET OF OIL	POL	211:
mova ical		23. PART I. Enter the diseases, or c	omplications that cause	d the deeth. Do no	ot enter the m	ode of dying, suc	h as cardiac or respi	ratory arrest.	Approximate
A OF		ehock, or heart failura. I	list only onal cause on e	ech line.			- m		Interval Between Onset and Death
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를 통합		PART II. Other algnificant conditions	s contributing to death b	out not resulting in	n the underlyl	ng caues givan in	Part I. 24a. WAS AN	AUTOPSY	4b. WERE AUTOPSY FINDINGS
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State Dept State Dept Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. [PLACE OF DEATH (Ch	1-1		
DIRECTOR: After this certificate in ours after death with the State Commented, or item	YSI	1 WES ZONO NO	1 Inputient 2 ER/Out	patient 3 DOA		me 5 🗆 Raeldence	8 Other (Specify)		
fter this ce eath with t marked,		27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME	JRY W	JURY AT	28d. DEŞCRIBE HOW I	NJURY OCCURED	
After death s mar	BY	2 Accident Investigation	28e. PLACE OF INJURY	- At home term et		YES 2 NO	28f. LOCATION (Street of	and Mumber or Dun	of Bords Number
DIRECTOR: After nours after death item 28 is ma		4 Homicide 8 Could not be determined	building, atc. (Spe	cify)	inest, factory, off		City or Town, State)	ind Namber of Nor.	in Houte Number,
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4 2 =	M.		R: On the beale of axamination						e(s) end menner ee stated.
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₽ ≥ ₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE					4 141	00/10
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	GRYBO:					DAY 199	EAR	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 212-60-4562	1 🗌 M 2 💢 F	8 0 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 2-16-19	15 N	Country)	CE (State or Foreign	
TOR	90. FACILITY NAME (If not institution, give Johns Hopkins RESIDENCE OF DECEDENT		C.		more C		Balt		re City	
DIRECTOR	10e. STATE 10b. COUNT	cimore	1	ry, town on Loca Dundall				1000	1. INSIDE CITY LIMITS? YES 2 XNO	
FUNERAL	100. STREET AND NUMBER 7531 Holabir	d Ave		10	1. ZIP CODE 21222		10g. CITIZEN OF WHAT			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENDENT OF HISPA pecify Cuben, Mexico 2 X NO Specific	NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.) fy:	ns or No.— 14.	RACE — / Black, Wh Specify:	American Indian, hita, etc. White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT L		ON ost of working	16b. KIND OF BL	JSINESS/INDUST	TRY		
	1 17. FATHER'S NAME (First, Middle, Lest) Stephan Poto	cki	House	ewife		N/A ME (First, Middle, Meider Kapache				
TO BE	190. INFORMANT'S NAME (Type/Print) Stanley R. G			ADDRESS (Street	and Number or Rural	Route Number, City or Tox Baltimore	wn, State, Zip Coo		22	
	20a_METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other placa) St. Stanislaus Cem. 5-26 Baltimore, Md									
	21. SIGNATURE OF FUNERAL SERVICE LI	et Come	t Connelly Funeral Home of Dund 7110 Sollers Point Rd 21222							
	23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	aDUE/To (OR AS A	tine.	= 5+1	20 KE	th as cardiac or reap	piratory arrest	,	Approximate Interval Between Onset and Daati	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Hyper tens to was an autropsy performed? 1 yes 2 No							CON	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
CIAN: A	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?									
Y PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH Natural 5 Pending	HOSPITAL: Inpatient 2 ER/Oulpa 28e. DATE OF INJURY (Month, Day, Year)	28b. Tik	IE OF 28c. INJ	JURY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	EO		
ETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify)							Number,	
COMPLE		ICIAN: To the best of my knowle R: On the basic of examination						iuse(s) and	f manner ee stated.	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIED	but	ma		29c. LICENSE NUI	41	29d. DATE SIG	-2.7	-95	
	30. NAME AND ADDRESS OF PERSON WHE	ERT Del	TH (ITEM 27) (Type	News	1099	JHH, BI	A HIN	noc	mD.	
	MAY 2 4 1995" July	82. REGISTRARY SIGNA	4							



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	OR

TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

$\overline{}$	1,2010111111				IOAIL		DEA	* 1 1	ne	G. NU.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DE	ATH DAY	,	YEAR	3. TIME OF DEATH
9	ROSEMARY	С	GAJEV	NSKI					MAY	19		95	4:15 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	lest birthday)	IF UNDER			R 24 HRS.	7. DATE OF BIR			a. BIRTH	IPLACE (State or Foreign
	218-42-0415	1 🗆 M 2 💢 F	50	YRS.	MONTHS	DAYS	HOURS	MIN.	May 24		944	Mar	
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN	OR LOCATI	ON OF DE		1		NTY OF D	
<u>۳</u>	GREATER BALTIMOR	E MEDICAL	CENTER	3		T	OWSO	V				BAT.1	TIMORE
БI	RESIDENCE OF DECEDENT												
DIRECTOR	10e. STATE 10b. COUN	TY		10c. CIT	Y, TOWN O	R LOCAT	TION						10d. INSIDE CITY
	Maryland Bal	ltimore		I	Edge	mer	е						1 YES 2 X NO
A	10e. STREET AND NUMBER						, ZIP COD	E			10g. CIT	ZEN OF	WHAT COUNTRY?
E	9122 Avenue H	3					213	219		- 1	Ţ	JSA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN			13. 1	WAS DEC			C ORIGIN? (Spe	cify Yes			E — American Indian,
	1 Never Merried 2 Married	IF YES, GIVE W	YES 2 Z	NO	1	f yes, sp	2 X NO	n, Mexican Specify:	, Puerlo Rican, e	etc.)		Spec	k, White, etc.
В	3 Widowed 4 Divorced										.	Орос	White
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)		DECEDENT'S					16b. KIND	OF BUSI	NESS/INC	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +) //	ite. Do NOT u	se retired.)		SE OF WORKS	'Y					
Me I	12		F	House	wif	e			N/A	A			
Ö	17. FATNER'S NAME (First, Middle, Last)						18. MOT	NER'S NAM	E (First, Middle,	Malden S	umame)		
BE (Wilfred Heckn	nan					Lo	ouis	e Russ	sel	L		
	19a. INFORMANT'S NAME (Type/Print)		1	19b. MAILING	ADDRESS	(Street a	nd Number	r or Rural A	oute Number, City	or Town,	State, Zip	Code)	
2	Ronald Gajews	ski	9	9122	Ave	nue	В	Edg	emere,	, Mo	3 21	219	
	20e. METNOD OF DISPOSITION 1 Burlel 2 \(\tilde{\text{L}}\) Cremetion 3 \(\text{Ret}\)		20b. PLACI	E AND DATE	OF DISPOS	ITION (Na	ime of		DATE 2	20c. LOC	ATION —	City or To	own, State
	4 Donation 5 Other (Specify)	movel from State	Met 1	rematory or o	ther place)	tor	v		5-22 H	Ra 1 t	t.imc	re.	БМ
- 1	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE			22.	NAME A	ND ADDRE	SS OF FAC	ILITY				
1	¥1.+0 (DA	00	1									Dundalk
	22 DATE FOR THE MILE	act Con	mell	-		<u>711</u>	<u>0 Sc</u>	olle	rs Poi	int	Rd.	. 2	21222
	23. PART I. Enter the diseases, or shock, or heart fellure	List only one cau	se on each la	regith. Do i	not enter	the mo	de ot dy	ing, such	as cardlec or	r reapin	ntory an	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (Firm)				- 0.			. /	/	/			Onset and Death
	resulting in death)	. KI	ETRU	PE	=K[10	NE	AZ	41	201	AK	COM	A-64ROY
		DUE TO	OR AS A CONS	EOUÉNCE O	F):	17	/ .		, /				1 11
8	Sequentially list conditions,	b			mT	5	LIVE	e /	YETA	51	TAS	15	A-6 year
CERTIFICATION	If any, leading to immediate ceuse. Enter UNDERLYING	DUE TO	OR AS A CONS	EOUENCE O	F):								
5	CAUSE (Disease or Injury	C	OR AS A CONS	COLUMN OF OR									
Ē	that initiated events resulting in death) LAST	DOE 10	OH AS A CONS	EUDENCE O	-):								
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	PART II. Other eignificant condition	ne contributing to	death but not	reculting	n the un	derlying	g ceuse (given in F	Part I. 24s. V	MAS AN A		24b	. WERE AUTOPSY FINDINGS
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¥	25. WAS CASE REFERRED TO MEDICAL	T CA		ACE OF DEAT			1 0140	EKIAIN					
PHYSICIAN:	EXAMINER? 1 YES 2 YNO	HOSPITAL:			OTHER	t:							
ξ∥	27. MANNER OF DEATH	28a. DATE OF		28b. TIM					28d. DESCRIBE	-		DILBER	
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à l	2 Accident Investigation	28° BLACE OF	IN ILIBY ALL	1000									
	3 Suicide 6 Could not be 4 Homicide determined	building,	INJURY — AI H	iome, tarm, i	Rreet, Tecto	ory, office	•		281. LOCATION (City or Town		d Number	or Rural F	Route Number,
COMPLETED													
릴	Check only 1 CERTIFYING PNYS	SICIAN: To Iha best of	my knowladga, d	death occum	d at the II	me, data	and place	, and due t	o the cause(s) a	ind mann	or as stat	ed.	
8	one) 2 MEDICAL EXAMIN	ER: On the basis of ex	amination and/o	r Investigatio	n, In my o _l	pinion, d	eath occur	red at the ti	ime, date and pla	aca, and	due to th	a ceuse(s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	ER (7	-a /		29c. LICE	ENSE NUME	BER	$\overline{}$	29d. DAT	E SIGNED	(Month, pay, Year)
BE		Junt	all	10	af			016			•	57	19/95 .
임	30. NAME AND ADDRESS OF PERSON W	NO COMPLETED CAUS	E OF DEATH (D	EM 27) (Type.	Print)							/	11/10
	Sompalli PRASAD 6701 N. Charles St. Baltimore, Md												
	31. DWAY "2" \$18957	ALL TO PROPERTY	S S VAT PE	1									
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11.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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NG PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 6 may be retained by the hospital or attending physician.	ifter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit the State Deut, of Health and Mental Hotelee prior to burial, cremation, or removal.	
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CERTIFICATION

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OR ATTENDING

Pages 1, 2, 3 should

95 15816 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Marion Harp May 22. 1995 8:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig Country) IF UNDER 24 HRS. March 11, 1979 Maryland HOURS 214-14-3601 1 X M 2 - F 76 YRS. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore 3708 Edgewater Place Dundalk RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore. Dundalk 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3708 Edgewater Place 21222 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Years Driver/Sales Brewery 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE Marion Harp Genevieve Alimo 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Venera K. Harp 3708 Edgewater Place Dundalk. Maruland 20a, METHOO OF DISPOSITION
1 2-Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Most Holy Redeemer Cem. 5/26/95 4 ☐ Donation 6 ☐ Other (Specify) Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 23. PART I. Enter the distance, or emplications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate IMMEDIATE CAUSE (Final Onset and Death heart disease disease or condition_ 15 Chamic resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Coronary arteri Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN VI 25. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 - Inpetlant 2 - ER/Outpetient 3 DOA 4 - Nurs ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO М

-22-95

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated. (Check only one)

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and menner as stated.

D3846

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)

ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4940 ENSTERN ROY ZIEGELSTEIN JOHNS HOPKINS BAYVIEW MED CTR BALTIMORE 1224 31. DATE FILED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

R ATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

ASPIRATION PARTIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TO BACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) EXAMINER? 1				
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TO SEE AS DIMENSEN TO 3 E. 43rd Street 17. MANTAL STATUS 18. More Married 2 (\$\) Married 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED FORCES? 1 (\$\) YES 2 (\$\) NO 19. MAS DECEDENT EVER IN U.S. AMED 19. MAS DE				
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203. PLACE and provided to the control of the con				
22. NAME AND ADDRESS OF FACILITY March Funeral Home East 101 E. North Avenue/Baltimore, MD 21. 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, intervious or condition and contributing in death) 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, intervious or condition and contributing in death) 24. NAME AND ADDRESS OF FACILITY March Funeral Home East 101 E. North Avenue/Baltimore, MD 21. Appropriate intervious and contributing and contributing in death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, intervious and contributing in death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation intervious and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation intervious and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, propriation and contributing indeath. Do not enter the mode of dying, such as cerdiac or reepiratory				
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONS	WEEK			
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2 Accident investigation				
3 Suicide 8 Could not be 28e. PLACE One INJURY — At home, ferm, straet, factory, office 28f. LOCATION (Street and Number or Rural Route Number,				
3 Suiches 4 Homicide S Could not be determined S Could				
29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated.				
(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and manner se stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and manner.				
	in stated			
herathene, M.D. DOUGH BOTH DOUGH				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)	per)			
ROWENA CASTRENCE, M.D. GOOD SAMARITAN HOSPITAL STOIL LOCH RAVEN BLVD BALTIMORI	per)			
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BALTIMORE, MARYLAND 21215-0020

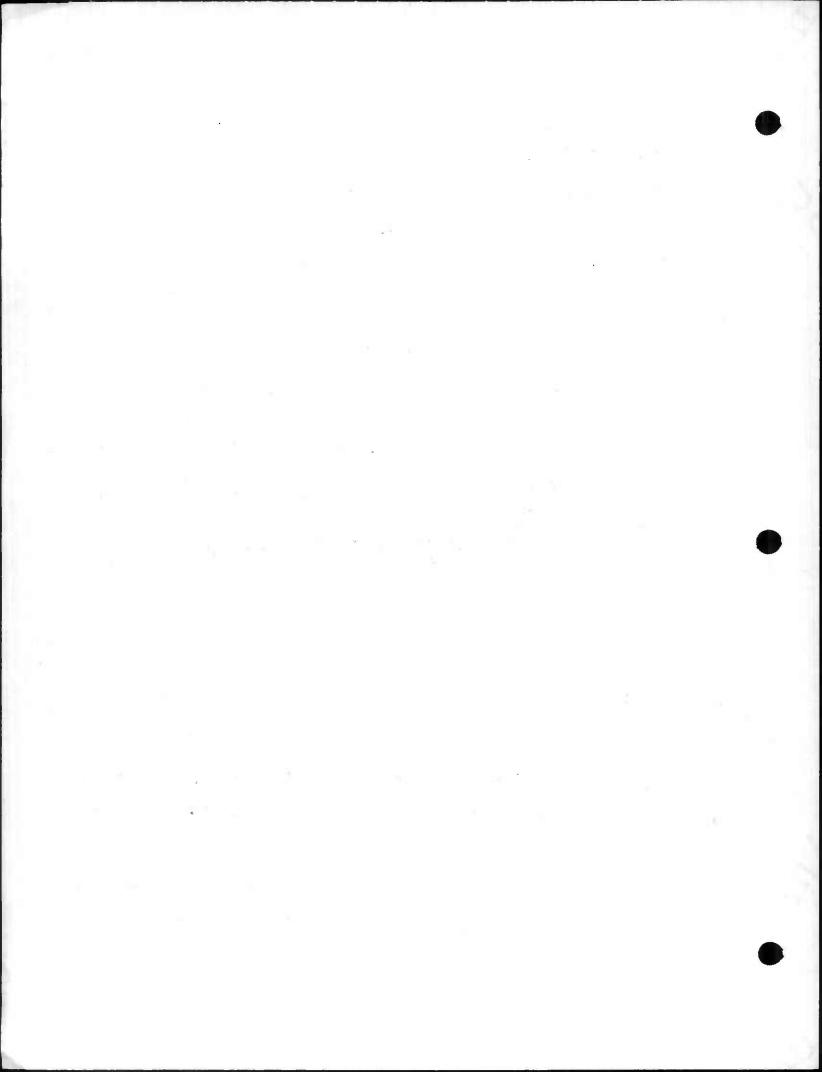
DIVISION OF VITAL RECORDS, P.O. BOX 68769

MAY 2 4 1995

at the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or artending physician.	R. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1.2.3	and Mental Hygiene prior to burlal, cremation, or removal.	y injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JAMES** MAY 20,1995 HUNTER 13:00 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 🔀 M 2 🗌 F 249-72-7779 51 09-19-43 SC. 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SHOCK TRAUMA UNIT BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. N/A BALTIMORE 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1213 21237 63RD STREET USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, stc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY 3 Widowed 4 Divorced Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 185 KIND OF BUSINESS/INDUSTRY (Specify or Elementary/Secondary (0-12) College (1-4 or 5+) 6th CONSTRUCTION WORKER UNK 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle Maiden Surname) **JAMES** A. HUNTER BE SR. SUSSANNA OWENS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BALTO. MD. 21237 1213 63rd GLORIA HUNTER 20s. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State KING MEMORIAL PARK 05-25-95 RANDALLSTOWN MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217 PART I. Enter the diseases, or com ncations that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure List only one cause on each line Interval Batw IMMEDIATE CAUSE (Finel Onset and Death disease or condition Custa resulting in death) DUE TO (OR AS A COMSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL YES 2 NO OF DEATH? VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER: TY YES 2 NO 1 X Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street and Number or City or Town, State) 1 Natural М 20/91 1 YES BY 0010 2 Accident 28a. PLACE OF NJURY — At home, term, street, factory, offica building, stc. (Specify) 3 Suicide ETED 8 Could not be 4 Nomicide determined COMPL 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 💢 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and ma 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MAY 21,1995 OCME 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



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296. SIGNATURE AND TITLE OF CERTIFIER

2. KRISHNAN

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD

Julia DA REPISTRA P SIGNATURE

821

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four star death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEFAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho filled within 72 hours after death with the State begin of health and Mental Hygiene prior to burial, cremation, or remove, no series after death with the State begin of health and Mental Hygiene prior to burial, cremation, or removed in them. The state begin of health and with light, or other traumatic event, the medical examiner must be netified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hos TO THE FUNERAL DIRECTOR: After this certificate has been signed by the afteroding physician and completely filled in by the funeral director, page 5 should be detach to fill with the State Dept. of Health and Mental Hygine prior to burish, cremoval. To hours after death with the State Dept. of Health and Mental Hygine prior to burish, cremoval. IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

95 15819 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 6:45 A HODGES MAREL May BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BATH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS 1 - M 2 1 68 YRS. 248-36-1675 03-13-27 S.Carolina 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Bon Secours Hospital Baltimore N/A DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore MD. N/A 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S. 1102 Ashland Court 21202 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2-100 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: Black IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 11th 0 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Niles BE Ida Lee Macon 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carolyn Hodges 1102 Ashland Court Balto, MD, 21202 90 20s. METHOD OF DISPOSITION
1 (Burisi 2 Cremation 3 Removal from State
4 Denation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE metery, cremetory or other place)
Cedar Hill Cemetery 5/95 Glenburnie, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 1721-27 N.Monroe St. Toutha CFSP#281 Balto., MD.21217 E.L. Phillips F/H 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or haart fallura. List only one ceuse on each line Interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition me -UN 4 CANCER mo. resulting in death) event, OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one **EXAMINER?** HOSPITAL:
1 Pinpetlent 2 ER/Outpetlent 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO В 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 🗌 Homicide 29s. CERTIFIER
(Chack only)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and menner ea stated.

29c. LICENSE NUMBER

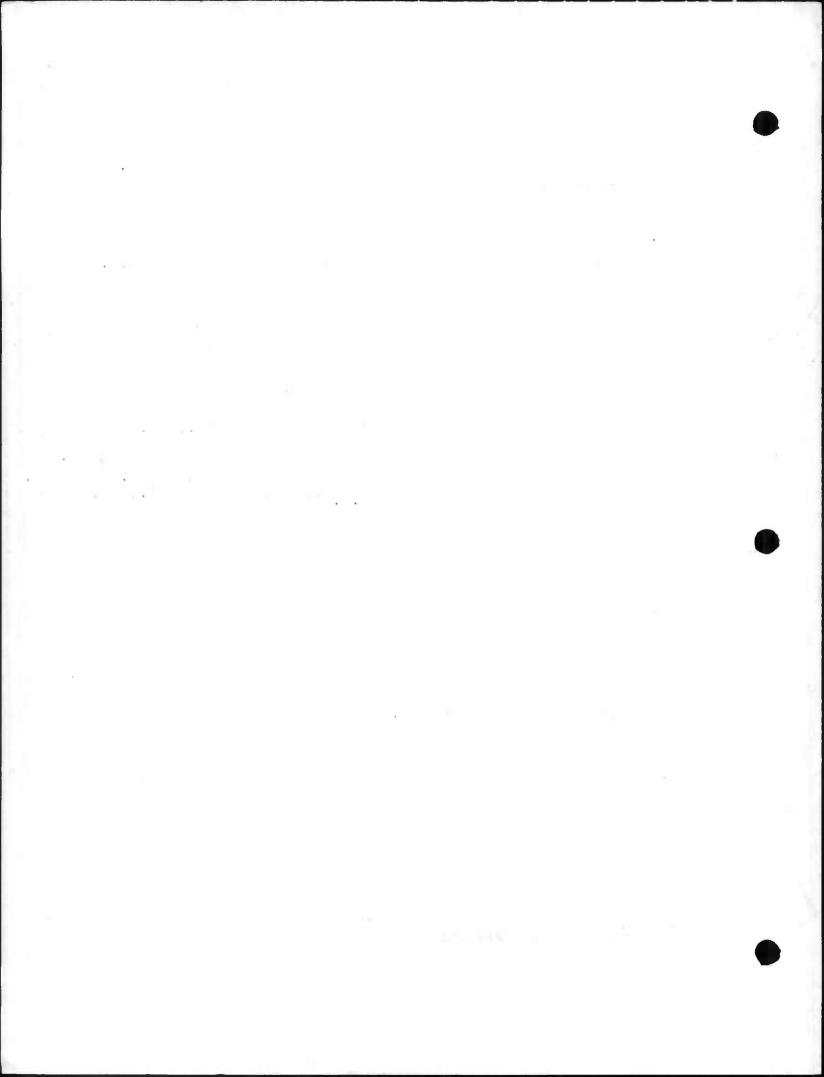
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29d. DATE SIGNEO (Month, Day, Year)

► 5-22-95

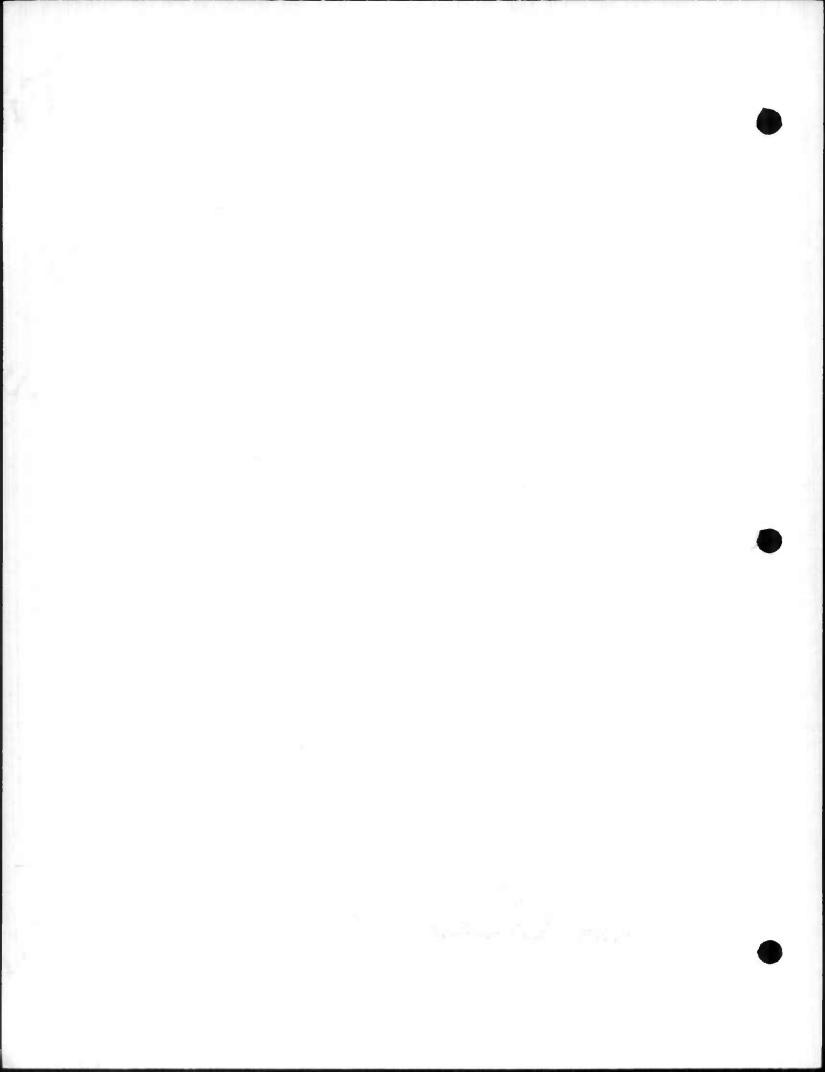
1 305 BALTIMORE 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEATH	
	JOHN A.	HARTSOC	K			Мач		199	YEAR 5	3:30 A M	
	1380 O. H. C. C. C. C. C. C. C. C. C. C. C. C. C.		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			LACE (State or Foreign	
	220-36-7585 9a. FACILITY NAME (If not institution, give stre	1 M 2 □ F 5.	4 YRS.	Sh CITY TOWN C	HOURS MIN.	7-2	24-194		Mar	yland	
DIRECTOR		2301 Lodge Farm Road Edgemere Baltime									
EC	10e. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	'ION				1	10d. INSIDE CITY	
	Maryland Bal	timore		Edgemer						LIMITS?	
FUNERAL	2301 Lodge Far	m Poad		10f	ZIP CODE					IAT COUNTRY?	
JNE		12. WAS DECEDENT EVER IN	II S ADMED	12 344 000	21219 ENDENT OF HISPAI		10 10 11 11		JSA	4 1 2 2	
	1 Never Married 2 X Married	FORCES? 1 YES	2 X 10	If yes, sp	ecify Cuben, Maxica	in, Puarto	Rican, atc.)	or No-	Black,	— American Indian, White, etc.	
ВУ	3 Widowed 4 Divorced	I TES, GIVE VIAN ON DAI	Ea	I I I IES	2 XNO Specif	у:			Specify	White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16a. DECEDENT'S	USUAL OCCUPATIO	ON st of working	168	. KIND OF BUS	SINESS/INDUS	STRY		
W.	Elementary/Secondary (0-12)	College (1-4 or 5+)		rork done during mo e retired.)	or or morning						
MP	12		Driver				Sun F				
	17. FATHER'S NAME (First, Middle, Last) Joseph Hartsoc	ale			16. MOTHER'S NA			Sumame)			
B	19a. INFORMANT'S NAME (Type/Print)	- K	T tob MAH INO	ADDRESS (Over 1	Katie						
2	Kathy Hartsock	•			nd Number or Rurel					01010	
	20g. METHOD OF DISPOSITION	205	PLACE AND DATE O		Farm I	K CI DAT		CATION - CH		21219	
	1X Burial 2 Cremation 3 Ramov	val from State ceme	tery, crematory or of	her place)		1	27 Ba				
	21. SIGNATURE OF FUNERAL SERVICE LICE		rdens		th Cem	CILITY	Z/ Da.	LCIMO	ile,	Mu	
	Dath Ca	0+ 6-	01.	Conr	nelly F	une	ral H	ome o	f D	undalk	
	23. PART I. Enter the discusses, Dr co	mplications that caused	the fleath Do n	711(Solle	rs	oint	Rd	212		
	shock, or heart failure. Li	st Dnly Dne cause Dn ea	ch line.		de or dynig, suc	11 35 CSI	arac or respi	ratory sires	ıt,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	Wastand	1		1 0 (Onset and Death	
	resulting in death) a.	DUE TO (OR AS A	CONSEQUENCE OF):	logent (on	cont.	The same of the sa			
z										İ	
10	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
TIE	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
Ë	d.										
AL C	PART II. Other significent conditions	contributing to deeth bu	t not resulting i	n the underlying	ceuse given in	Part I.	24a. WAS AN			VERE AUTOPSY FINDINGS	
S							PERFOR		0	MAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC										OF DEATH?	
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S 🗆 NO 🗆	UNCERTAIL	<u>ч</u> 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEAT								
YSI	1 TYES 2 NO	1 Inpatiant 2 ER/Outpat	tient 3 🗆 DOA	OTHER: 4 Nursing Home	5 Realdence	6 🗆 Othe	r (Specify)				
PH	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJI	URY AT RK?	28d. DES	CRIBE HOW II	NJURY OCCU	RED		
BY	1 V Netural 5 Pending 2 Accident Investigation			M 1 7							
3 Suicide 6 Could not be datarmined 4 Homicide 4 Homicide City or Town, State) 28s. PLACE OF INJURY — At home, farm, etreel, factory, office building, arc. (Specify) 28s. PLACE OF INJURY — At home, farm, etreel, factory, office City or Town, State)									ute Number,		
COMPLET	29a. CERTIFIER 1 Y CERTIFYING PHYSICI	AN: To the best of my knowle	dos dosth soor	d at the time does	and alone == 4 d	An Ah : -	matel and a				
Ř		On the basis of examination								and manner se stated	
	199. SIGNATURE AND TITLE OF CERTIFIER	. 1		1			_ w proces, are				
B	Vace Aval	6 1 uso	,		29c. LICENSE NUR	2 P	5	29d. DATE S	IGNED (A	Aonth, Day, (Year)	
2	30. NAME AND ADDRESS OF PERSON WHO			Print)	1166	20	1	d	100	3/~	
	Paul A. Valle,	Jr. M.D.	1012		oint R	d F	Baltin	nore.	_Md	21224	
	MAY 2 4 1995	REGISTRARY LIGHT	A.E.								

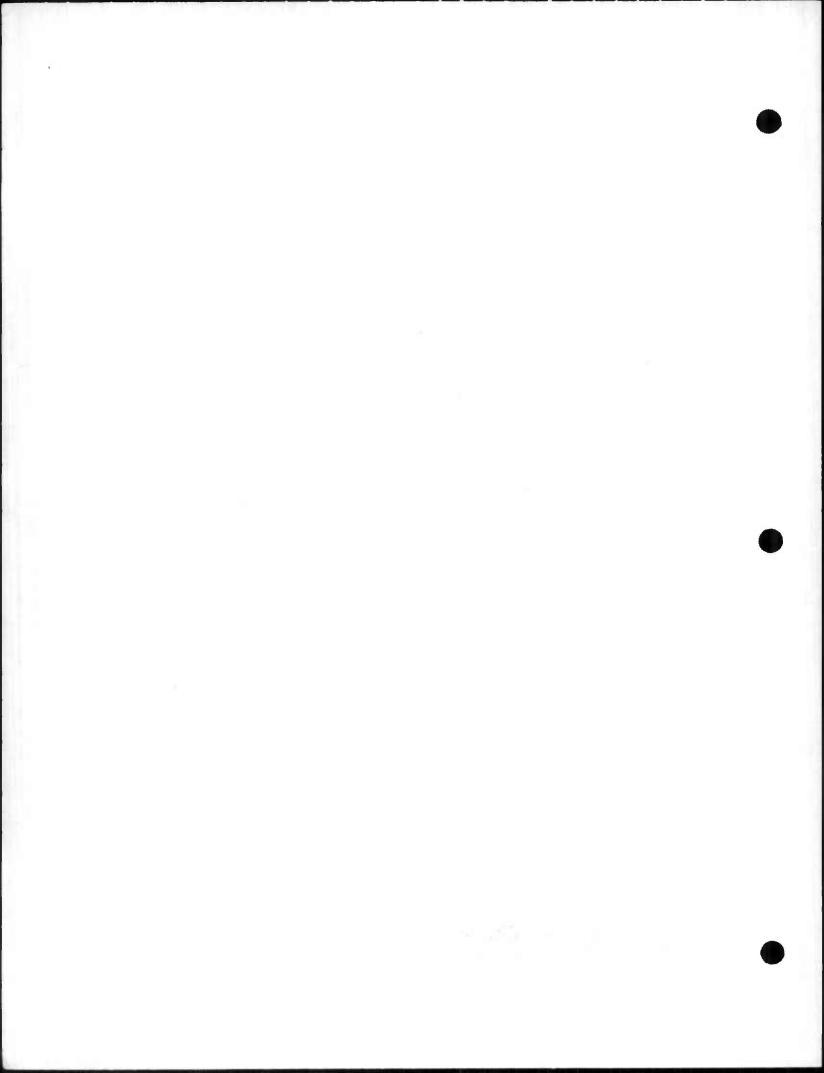


BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filled within 72 hours after death with the State Dest. of Health and Merital Hydiene prior to burial, cremation, or removal.	MPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
	ITANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, it

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

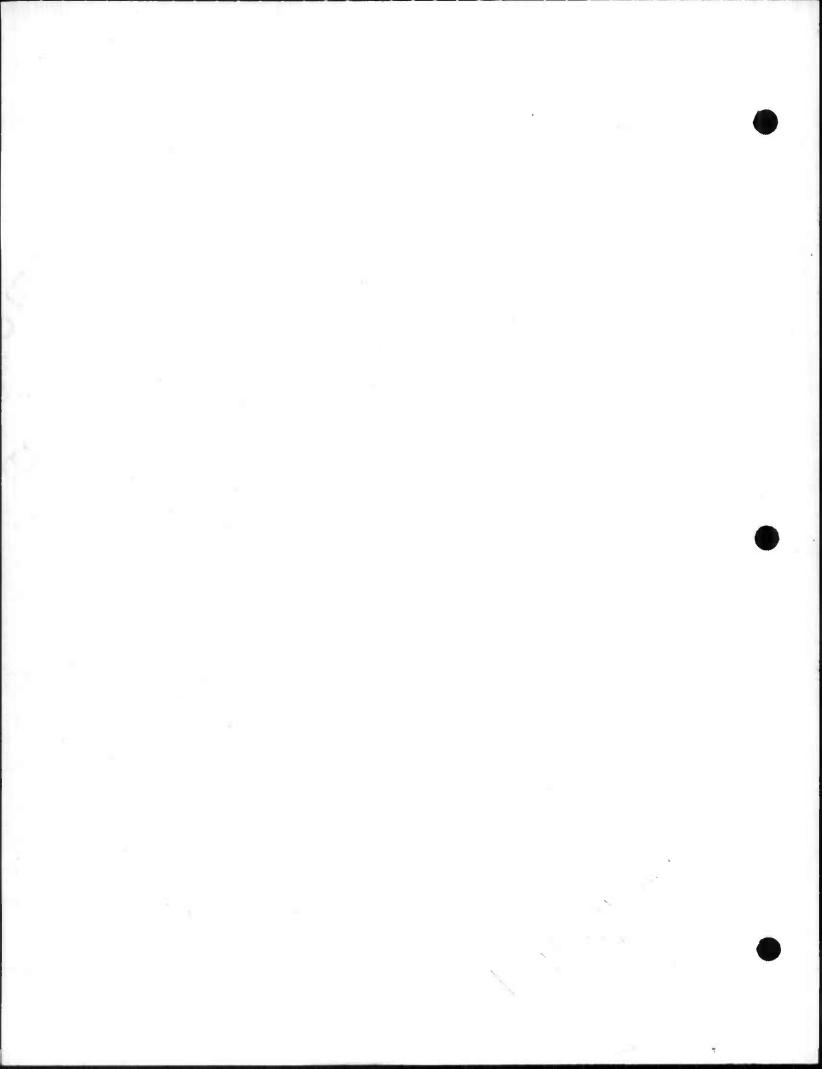
	HEGISTHAH		CERT	FICALE	OF DEA	H	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) Clarence Edwin					ľ	2. DATE OF DEATH	1995	YEAR	TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 578-05-8185		NGE (In yrs. last birthde 3 1 YRS	MONTHS	YEAR IF UNDE	MIN.	7. DATE OF BIRTH CL. 23,1	913	8. BIRTHPLAN Country) Misso	CE (State or Foreign		
	9e. FACILITY NAME (If not institution, give :	street and number)		9b. CITY,	TOWN OR LOCAT	ION OF DEA	TN	9c. COUN	ITY OF DEATH	1		
CTOR	4096 Cadle Cre			Mayo)			An	ne Ar	undel		
	4096 Cadle Creek Road Mayo Anne Arun RESIDENCE OF DECEDENT 10e. STATE MD NUMBER 4096 Cadle Creek Road 10e. CITY, TOWN OR LOCATION Mayo 10e. STREET AND NUMBER 4096 Cadle Creek Road 10f. ZIP CODE 21106 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 CANO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Ves or No- IR RIGGE, White, at											
ERAL												
1 5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED	13. W	AS DECENDENT	OF NISPANIC	C ORIGIN? (Specify Yes	or No-	14. RACE - /	American Indian,		
BY	3 Wildowed 4 Divorced NF YES, GIVE WAR OR DATES TO 1 YES 2 W NO Specify: Specify: White											
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDEN' (Give kind	T'S USUAL OCC of work done du	CUPATION ring most of work	ina	16b. KIND OF BUS	INESS/IND	USTRY			
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)					Drint	1 22 00	TMA	+		
N N	17. FATNER'S NAME (First, Middle, Last)	3	PLI	nter			Print		INdus	stry		
	Carl Cleveland	Harlowe					e (First, Middle, Meiden : Marie Jo:					
H	19a. INFORMANT'S NAME (Type/Print)	nariowe	105 MAII	NO ADDRESS			ute Number, City or Town					
٥	Marquerite B.	Harlowe					oad, May			106		
	20s. METHOD OF DISPOSITION 55.38 urist 2 □ Cremation 3 □ Rem 4 □ Docustion 5 □ Other (Specify)	oval from State	20b. PLACE AND DATE COMMETTER COMMET	v other place!					onvil			
	21. SIGNATURE OF SUMERIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Hardesty Funeral Home, P.A.											
	23. PART I. Enter the diseases for	complications that car	used the death. D	o not enter ti	ha mode of dy	ing, such	as cardiac or reapi	apo L	at,	Approximate		
1	PART L Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, interval Between Onset and Death IMMEDIATE CAUSE (Final)											
	disease or condition resulting in death)	· (a /	hutte						İ			
		DUE TO (OR .	AS A CONSEQUENCE	OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR .	AS A CONSEQUENCE	OF):								
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	c.										
불	that initiated events resulting in desth) LAST	DUE TO (OR .	AS A CONSEQUENCE	OF):								
H	Todama and cooling Exist	d										
	PART II. Other algnificant condition	s contributing to dea	th but not resultin	g in the und	eriying cause	given in Pa			24b. WER	E AUTOPSY FINDINGS		
EDICAL							PERFORI		COM	LABLE PRIOR TO IPLETION OF CAUSE		
MEC						-	_ 10 125 2	K		DEATN?		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES N	O ZZ UNO	CERTAIN	<u>- </u>		1	, 120 2		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DI		ly one)							
SI	1 VES 2 NO	HOSPITAL: 1 Inpatient 2 ER/	Outpatient 3 - DOA	OTHER:	g Home 5 K R	esidence 6	Other (Specify)					
	27. MANNER OF DEATN 28a. DATE OF SNJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO											
2 Accident 3 Sulcida 6 Could not be determined determined determined determined										Number,		
COMPLET	29a. CERTIFIER A CERTIFYING PHYSI							_				
₩	(Check only	CIAN: To the best of my k										
8		R: On the besis of examin	anon and/or investiga	поп, и ту орн	nion, death occu	red at the tin	me, data and place, and	due to the	cause(a) and	manner sa stated.		
TO BE	296. SIGNATURE AND TITLE OF CENTRIES	un de			D7	ENSE NUMBE	ER / 8	29d. DATE ▶ 3	SIGNED (Mon	th, Day, Year)		
F	30. NAME AND AUTORESS OF PERSON WH						D 21404	/				
	Dr. Watkins, 6	W BESTG	ace Road	a, Ani	napoli	s, M	D 21401					
	MAY 2 4 1995	P. REGISTRARIOS	Als II									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FilmG, 723, item #1, 5/24/95,cyw, per f.h.

	1 - STATE REGISTRAR	SIAIE UF MA					DEAT		WEN IAL	REG. NO.	Ŀ			
	1. DECEDENT'S NAME (First, Middle, Last)	ALAN							2. DATE OF MONTH	DA	ΛY	YEAR	3. TIME OF	OEATH
		THE THE PARTY OF T							MAY	16	199	95	2:1	
	002-62-2191	1. SEX 6	1. AGIE (In yrs. lest bi	YRS.	IF UNDER MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, C	20°1	975	Uta	IPLACE (Stere	or Foreign
	9e. FACILITY NAME (If not institution, give stre	set and number)			9b. CITY,	TOWN O	R LOCATIO					NTY OF D		
OR	ANNE ARUNDEL G	ENERAL H	HOSPITA	L	AN	NAP	OLIS				ANI	NE A	RUNDI	EL
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			IOc. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE	CITY
	MD Anne	Arundel		Edg	gewa	ter						- 2	LIMITS1	
FUNERAL	100. STREET AND NUMBER 447 Walnut Driv	7e					ZIP CODE 1 0 3 7				1	IZEN OF W	VHAT COUNTS	977
B∀	11. MARITAL STATUS 11/2 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT IF FORCES? 1 F YES, GIVE WAR	YES 2 NO	D	11	yes, spe	ENDENT OF cify Cuban 2 M NO	HISPAN Mexicen Specify:	IC ORIGIN? (1 n, Puerto Rice	Specify Yee en, etc.)	or No-	14. RACE Black Speci	— American k, White, etc.	
TED	15. DECEDENT'S EDUCA (Specify only highest grade of		18a. DECEI (Give	DENT'S	USUAL OC	CUPATIO	N It of working		16b. KI	NO OF BUS	INESS/INE	DUSTRY		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		ude					F	duca	tion	,		- 1
COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM	ME (First, Mide					
BE C	JOhn Alan Ingbre	tson							Ange:					
0	190. INFORMANT'S NAME (Type/Print) Faith Ingbretso	n Monni							oute Number, Edgev				1027	
	20e. METHOD OF DISPOSITION		20b. PLACEANE					-,	OATE		CATION —			
	1 Donation 5 Other (Specify)	- /1	Metro	Cr	emat	tory	7		5/19				, MD	- 15
	21. SIGNATURE DE FUNENJA. SERVICE LICE	11			Ha	arde		Fu	neral	L Hoi	me,	P.A		
CERTIFICATION	23. PART I. Enter the disease, or co ahock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (O	on each line.	NCE OF	WRI	the mod	de of dyln	g, such	as cardiad	or reapi	ratory arr	reat,	Appro	ximata al Between and Death
	d.													
MEDICAL	PART II. Other significant conditions	contributing to de	eath but not read	ulting i	n the unc	derlying	cause gi	ven in F		PERFOR	MED?	24b.	WERE AUTOPS AWAILABLE PR COMPLETION OF DEATH? 1 YES 2	OF CAUSE
N.	DID TOBACCO USE CONTRI	BUTE TO CAU	SE OF DEATH	YE	S 🗆 N	10 12	UNCE	RTAIN						
PHYSICIAN:		HOSPITAL:	26. PLACE C		H (Check o									
HYS	1 Syes 2 NO	1 Inpetient 2 F E	JURY 2	DOA 8b. TIMI		ing Home		idence 8	8 Other (S		I II IBV OC	CHIPPO A	. 1	
	1 Natural 5 Pending	5/5/9	year)		URY	WOF	IK?	NO I	DELVIST	? RF	MANTA	SC.X	1/15/09/	EIVED
3 Sutcide 8 Could not be building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street end Number or Run City or Town, Steet)									or Rural R	oute Number, (16320			
COMPLET	29e. CERTIFIER (Check only one)				d at the tir	ne, date							DAVILL	0 /00/2
S	2 MEDICAL EXAMINER	On the basis of exen	nimitton end/or Inve	stigatio	n, in my op					d place, end	due to th	e ceuse(s)	end manner	ee stated.
386	256. SISNATURE AND TITLE OF CENTIFIES	All-	H) J				O .	C . M					(Month, Day, V	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	M(C)	, . , ,		tre	et.	Bal	timo	re.	Mars	/lan	d 212	201
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE						02410		141		~ ~	
	MAY'2 4 1995	Jali de	walen-Ran	tall						<u> </u>				



by the hospital or attending physician. be detached for use as the bunal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

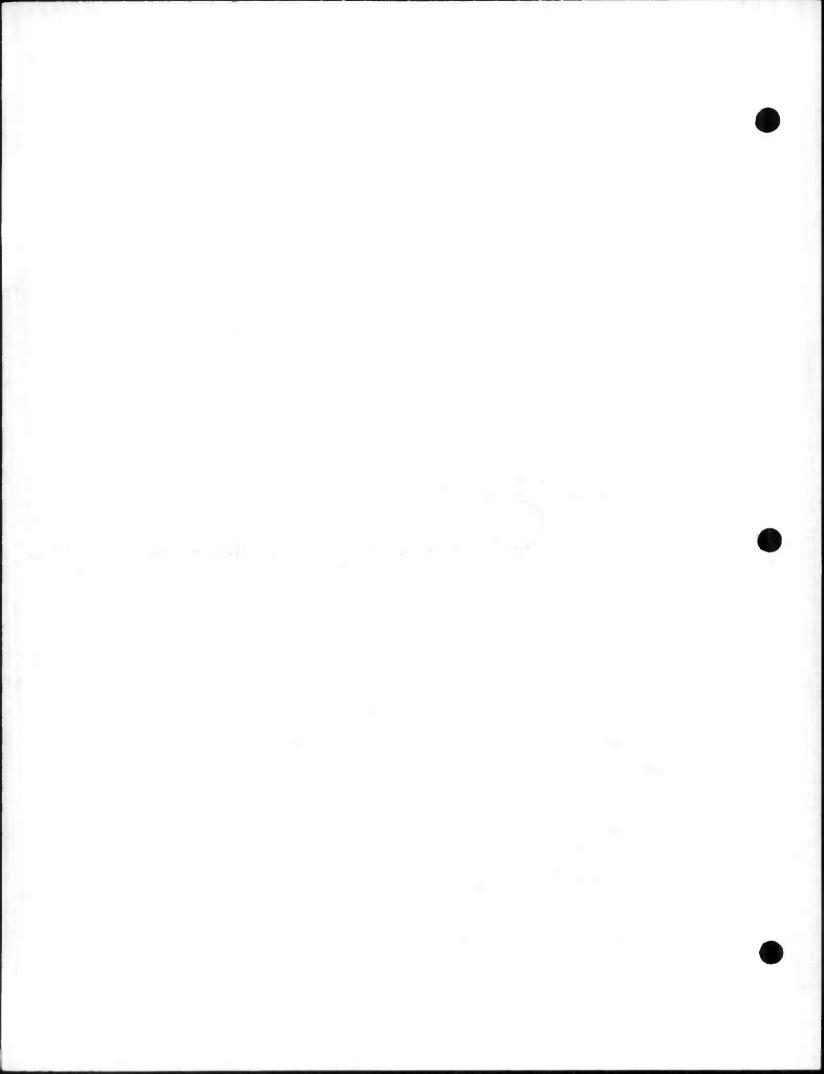
TO THE HOSPITAL OR AUTENDING PHYSICIAN. The law requires that the death certificate be executed within an hours after death. Page 6 may be retained to	TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burtal, cremation, or removal.	IMPORTANT. If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified	
Page 8 n	director	Der mu	
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nours after	d in by to or remo	medica	
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OR DE OR	prior to b	trauma	
certifics	Anglene Hygiene	or other	
the death	the atte	njury, c	
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AN: The	thcate to State D	r Item	
PHYSICI	this cert	erked, o	
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L 08 AT	DIFFECT HOURS IF	Item 2	
HOSPITA	FUNERAL WITH 72	TANT: II	
보유	THE SE STATE	IMPOR	

6

31. DATE FILED (Month, Day, Year) MAY 2 4 1995

	FOR 1 - STATE	STATE OF	MARYLAND_	/ DEPAF	RTMEN	IT OF H	IEALTH	AND I	MENTA	L HYGIEN	E	20	15823
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		C	ERTIF	ICAT	E OF	DEA	ТН		REG. NO			
	· · · · · · · · · · · · · · · · · · ·								MONT	OF DEATH	AY	YEAR	3. TIME OF DEATH
	Mary Belle Jones 4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	and bloth days						19, 199	5		0915 N
	212-68-7323	1 M 2 V F	59	YRS.	MONTHS	DAYS	IF UNDER	MIN.	(Mon	th, Day, Year)		Coun	
			39		0b CIT	V TOWN C	D 10047	ON OF 00		L 8, 19	_		RYLAND
DIRECTOR	RESIDENCE OF DECEDENT											WARD	
Diameter 1												10d. INSIDE CITY	
뜸	MADVI AND										LIMITS?		
	10s. STREET AND NUMBER					_	. ZIP COD	E			10a. Cl	TIZEN OF	WHAT COUNTRY?
FUNERAL	9645 M. HOMESTEAD COL	JRT					207	23			7,10	USA	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	RMED	13	. WAS DEC	ENDENT C	OF HISPAN	IIC ORIGI	N? (Specify Yes	or No-		E — American Indian, k, White, etc.
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE V	MAR OR DATES	NO		If yes, spe	ecity Cube 2 XX NO	n, Mexica	n, Puerto	Rican, etc.)			ck, White, etc. CHY: WHITE
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade	ICATION	16a. D	ECEDENT'S	USUAL (OCCUPATIO	ON		161	. KIND OF BUS	SINESS/IN	IDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	- 4	Give kind of the Do NOT us	work done se retired.	auring mo:	st of working	19					
MP I	12	Ø		DAY CH	EF	-	_		F	ESTAURA	NT		
8 8	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	NER'S NA	ME (First,	Middle, Meiden	Surname)		
BE	SAMUEL H. WATTS						ELSI	E BEL	LE GO	SNELL			
2	19e. INFORMANT'S NAME (Type/Print)								Route Num	ber, City or Town	n, State, Z	ip Code)	
	LAURA TSCHIRHART			9551 L	INVIL	LE AV	ENUE,	L	AUREL	MAI	RYLAN	D 20	0723
	20s. METHOD OF DISPOSITION tXX Surial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	rovel from State		WRIDGE					5/2	3		E. MAI	own, State RYLAND
	21. SIGNATURE OF FUNERAL SERVICE LA	edila	ada	,	22	7601	Sandy	Spri	ng Ro	Fleck Frad, Lau	unera rel,	1 Home Maryla	
ERTIFICATION	23. PART. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. Aletony one cau	COR AS A CONSE	EQUENCE OF	ali					Union		rrest.	Approximate interval Between Onset and Death
15	resulting in death) LAST	d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO									346	WERE AUTOPSY PINDINGS ANALASILE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN	1				
PHYSICIAN:	25. WAS CASE REFERRIED TO MEDICAL EXAMINERY 1 YES 2 700	HOSPITAL:		DOA	OTHE	RI:	s da	sidence (8 🗆 Othe	r (Tipmolly)			
ву РН	27. MANNER OF DEATH 1 Matural 5 Pending	28s. DATE OF INJURY (Mont. Chr. War) 28b. Time OF 28c. INJURY AT WORK? (Mont. Chr. War) 1NJURY WORK?							284. DEI	CRIBE HOW IS	NURY DO	CURED	
03	3 Stuicide 6 Could not be 4 Homicide determined	2 Accident 3 Suicide 6 Could not be building set. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, set. (Specify)							281, LOC City	LOCATION (Street and Number or Rural Roum Number, Olly or Den, State)			
COMPLET	29s. CERTIFIER GERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE												i) and manner as stated.
2 MEDICAL SEAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course(x) 29s. SIGNATURE AND TITLE OF CENTIFIER 29st. DATE SIGNES (X)										(Manny Day, Year)			

who completed cause of DEATN (ITEM 27) (Type, Print)
tis 8037 Laurel Lakes Court, Laurel, MD 20707 Bruce Wayne Gattis 32. REGISTRAR'S SIGNATURE



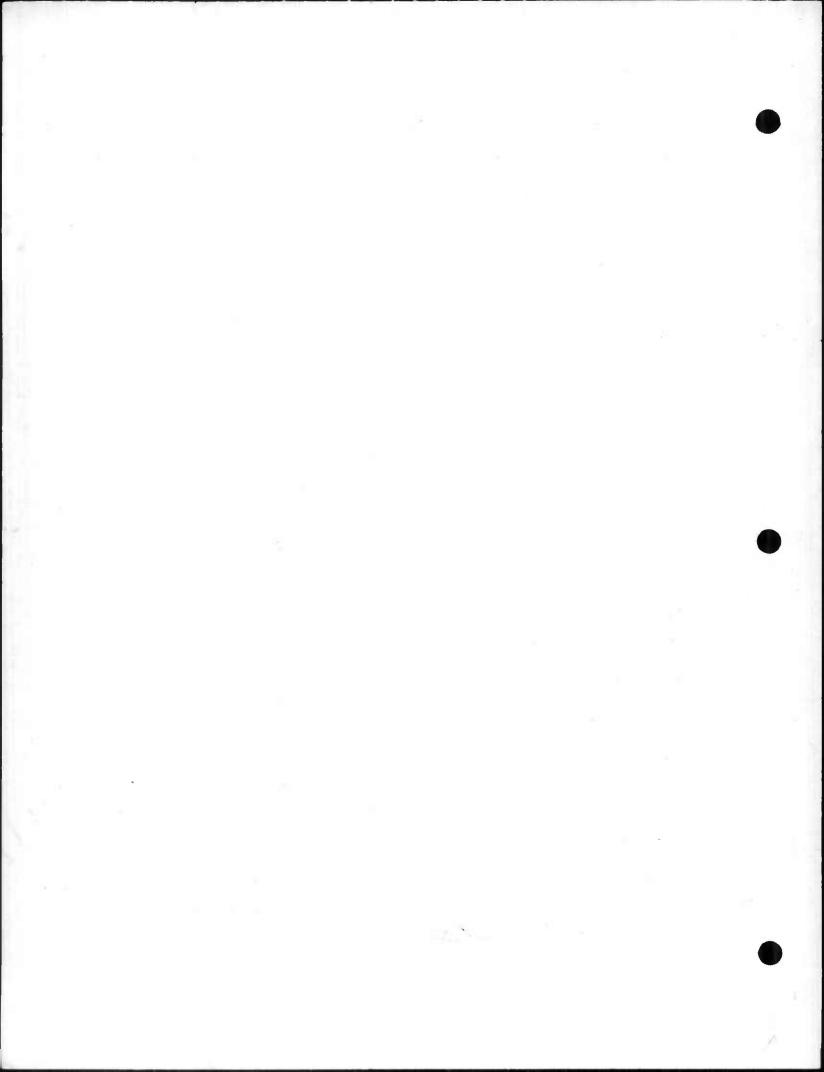
BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMENT OF HEALTH CERTIFICATE OF DEA
1. DECEDENT'S NAME (First, Middle, Last)		

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (Firs	1. DECEDENT'S NAME (First, Middle, Last)					2	. DATE OF DEATH		3. TIME OF DEATH
1	DELORE		IZABETH	JOHN	ISON		M	IAY 20,	1995 YEAR	20:05 P M
	4. SOCIAL SECURITY NUM 222-22-9722		5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTI							THPLACE (State or Foreign
O.B.	99. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 2624 ASGUITH ST, BALTIMORE RESIDENCE OF DECEDENT					9c. COUNTY OF DEATH 1/a				
DIRECTOR	10a. STATE MARYLAND	10b. COUNTY 10c. CITY, TOWN OR LOCAT					OD C			10d. INSIDE CITY V LIMITS? 1 YES 2 NO
VERAL					10f. ZIP CODE 21218				UNITED	WHAT COUNTRY?
BY FUN		11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 VES 2 NM IF YES, GIVE WAR OR DATES			MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea If yea, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:				s or No.— 14. RACE — American Indian, Black, White, etc. Specify: BLACK	
PLETED		CEDENT'S EDUCATION In this series of the composition of the compositio		(Give kin	NT'S USUAL OCC d of work done dur OT use retired.)	JPATION ng most of workin	ng		SINESS/INDUSTRY	
I at once.	17. FATHER'S NAME (First, Middle, Last) LEROY FRANKLIN LEE 18. MOTHER'S NAME (First, Middle, Melden Surname) LILLIAN SMITH									
TO BE	19a. INFORMANT'S NAME (Type/Print) LEROY E. JOHNSON JR. 19b. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7157 MC CLEAN BLVD., BALTIMORE, MD 21234									
must be	20a. METHOD OF DISPOSIT X Buriel 2 Crematic 4 Denation 5 Other	on 3 Removal r (Specify)	from State		ATE OF DISPOSITI		AR DE NS		UNDALK,	Town, State MARYLAND
examiner	21. SIGNATURE OF FUNERAL SERVICE LICENSEE **WM. C. MARCH FH1101 E. NORTH AVENUE**									
other traumatic event, the medical	IMMEDIATE CAUSE (Fit disease or condition resulting in death)	nal a	Blut DUE TO (OR A	S A CONSEQUENCE	Injur	e mode of dyli	temel	a cardiac or reep	iratory arrest,	Approximate interval Between Onset and Death
2 6	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
shows any Inju	PART II. Other signification						errain Par	PERFOR	MED?	NO. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
r item 23 SICIAN	25. WAS CASE REFERRED TEXAMINER? 1X YES 2 NO	O MEDICAL HC	DSPITAL:	26, PLACE OF	OTHER:	one)				
marked, or BY PHYS	27. MANNER OF DEATH 1 Natural 5	Pending Investigation	28e. DATE OF INJUIF (Month, Day, Yea	Y 28b	TIME OF 28	c. INJURY AT WORK?		d. DESCRIBE HOW I	NJURY OCCUREO	k
28 Is TED	3 Suicide 8	2 Accident 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, str. (Specific)						of Retrained		
COMPLE			: To the best of my kr	owledge, death oc	curred at the time					Maryland
IMPORTANT: If item TO BE COMPLE	296. SIGNATURE AND TITLE OF CENTIFIER Theolog Ut King up			L1D	29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year) MAY 2.1 . 1995		
		F PERSON WHO CO E M. K.	MPLETED CAUSE OF			treet,				and 21201
	MAY 2 4 19	95 Juli	PHOA TRAR'S	GNATURE						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ľ
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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2 DATE OF DEATH 3. TIME OF DEATH 18 1995 Mattie Jones Mattie Wiggins Jones May 3:30 р.т.м 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 227-12-1820 Virginia 1 - M 3 FEB 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HEalth (are Center permit. Pages 1, 2, 3 DIRECTOR timora RESIDENCE OF DECEDENT 10a, STATE IRC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore 1 YES 2 NO Mary land FUNERAL 141 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 33 N. AISQUITH STREE 21202 USA the funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 DINO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 Specify: 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL BOKER JUKNOW estor notified at once 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, UCKER 19a. INFORMANT'S NAME (% 21202 2 Baltimorme 9 D. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION /N must Cremation 3 | Donation 5 C Other (Specify) examiner 21. SIGNATURE OF FUNDAL SERVICE LICENSEE UDO Hairis HATMAN or removal. event, the medical 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. filled in by Approximate Interval Between IMMEDIATE CAUSE (Finel cremation, CONGESTIVE HEART disease or condition resulting in death) and completely DUE TO (OR AS A CONSEQUENCE OF) burial, TRONIC traumatic CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): 2 if any, leeding to immediate physician DM cause. Enter UNDERLYING CAUSE (Diseese or injury the attending physical of Mental Hygiene p or other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART il. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS 24a, WAS AN AUTOPSY PERFORMEO? Signed by the DEMENT IA MAIL ARLE PRIOR TO апу COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Shows has been s Dept. of H 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 23 25. WAS CASE REFERRED TO MEDICAL Item 2 26. PLACE OF DEATH (Check only one) h the State L EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 5 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) this c 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY 2 Accident After Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) Sulcide 261. LOCATION (Street and Number or Rural Routs Number, City or Town, State) 3 🗍 28 Is 8 Could not be COMPLETED DIRECTOR: after 4 Homicide determined E FUNERAL DI.
VITTIN TZ hours.
VT. II Item 29 29a. CERTIFIEN To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ea stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: B On the basis of axamination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end manner as stated. 29d. DATE SIGNED (Month 98), Year)

5 / 20 / 9 / 29c. LICENSE NUMBER 29b. SIGNATURE AND TITL BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Syon, Print, 31, DATE FILED (Month, Day, War) 32 REGISTRAN'S SIGNATURE DHMH-16 Rev 1/89

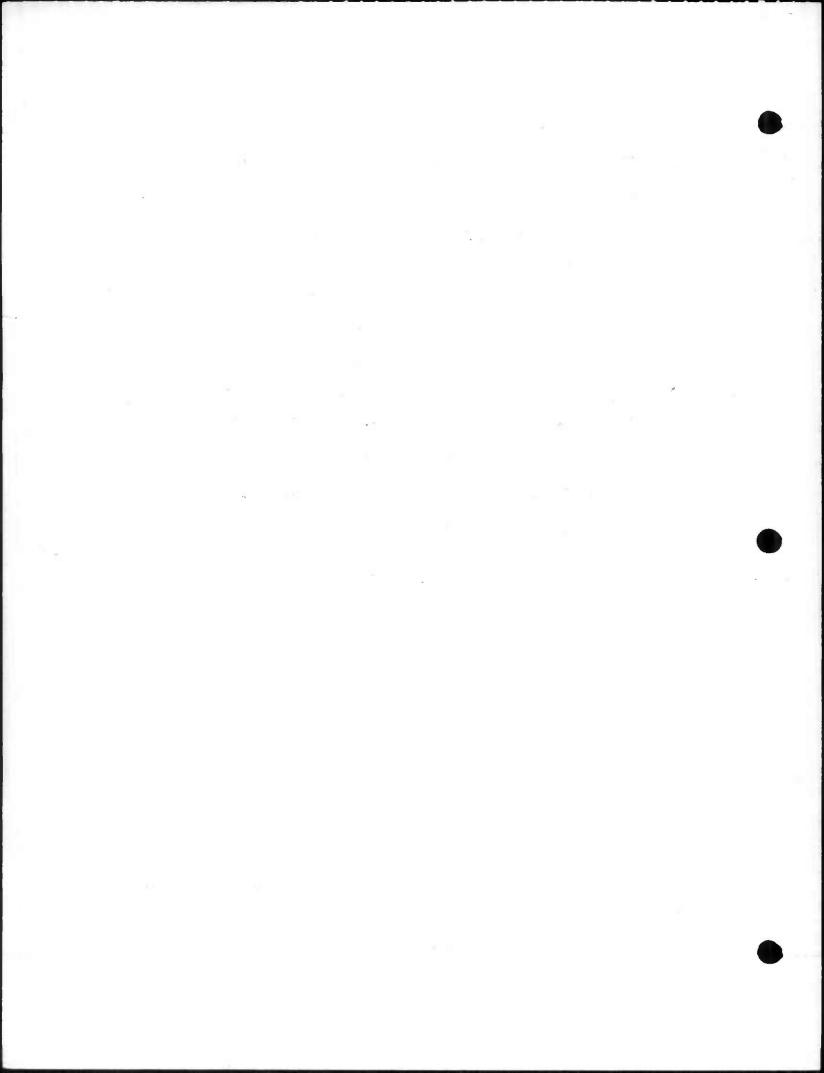
regard that are also as the area of the

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within za hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	APORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR	TO THE FUNERAL DIRK be filed within 72 hour	IMPORTANT: If Item	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTA	L HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEAT	
- 1	LOU	ISE MARY JON	NES			MA		995	YEAR	5:17	A
			"	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	7. DATE OF BIRTH 8. BIRTHPLACE ((Month, Day, Year) Country)			IPLACE (State or Fo	oreign
	213-30-6857	1 M 2 X F	79 YRS.	DAYS	HOURS MIN.		24, 191	6	MARYLAND		
~	9a. FACILITY NAME (If not institution, give stre	eet and number)		9b. CITY, TOWN (OR LOCATION OF D	EATH		9c. COUNT	Y OF D	EATH	
DIRECTOR	NATIONAL NAVAL M	EDICAL CENTE	ER	BET	HESDA			MO	NTG	OMERY	
띭	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION					10d. INSIDE CITY	,
片	MARYLAND P	RINCE GEORGE		LANH	AM					LIMITS?	NO
Y	10e. STREET AND NUMBER			101	. ZIP CODE			10g. CITIZE	N OF V	VHAT COUNTRY?	
틸	6907 NASHVILLE ROAD				20706	5			USA		
10e. STREET AND NUMBER 6907 NASHVILLE ROAD 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced 10g. CITIZEN 20706 11. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES, GIVE WAR OR DATES A 11. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:								or No- 1	I. RACE	- American India	en,
							Speci	WHITE			
	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S U			16b.	KIND OF BUSI	NESS/INDUS	STRY		_
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	rk done during mo retired.)	st of working						
를	12	Ø	HOMEMAK	ER			HOME				
ខ្ល	17. FATHER'S NAME (First, Middle, Last)	1501/			18. MOTHER'S NA			umame)			
BE	RICHARD WALTER STARSON	NECK			HILDA I						
၉	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural					707	
J. PATRICK EDELMANN 14411 BALTIMORE AVENUE, LAUREL, MARYLAND 2070 20e. METHOD OF DISPOSITION 1 (V. Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Camelary, crematory or other piece) WESTERN CEMETERY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME,											
	1 alagor	Unito	11	7601	SANDY SPE					•	707
-	23. PART I Enter the diseases, or co	molications that caused	Itse death Do no					-			
1	anock, or heart fautire. Li	st only one chase on a	ich üne.	t ontar tria mo	ua or uying, auc	on as card	nac or reapm	story arres	ι,	Approximation interval Be	etween
	iMMEDIATE CAUSE (Final disease or condition	1								Onset and	
ł	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	LUS						7 DAY	15
z	b.	METAST	ATIC BLA	DDER CA	NCER					3 YEA	ARS
	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)								
	CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE OF):								
RTIFICATION	that initiated eventa reaulting in death) LAST	-02 10 (011 NO N	CONSECUENCE OF J.							İ)
S	d.								_		
K	PART il. Other algnificant conditions	contributing to death bu	it not reauiting in	tha undariying	g cause given in	Part i.	24a. WAS AN A PERFORM		24b.	WERE AUTOPSY FI	10
ا ق						-	1 TYES 27	□ NO		OF DEATH?	AUSE
Ž	DID TODA COO LIST COA ITO	D		<u> </u>						1 TYES 2XX	10
AN	DID TOBACCO USE CONTRI		BEATH YES		UNCERTAI	NKX					
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:		OTHER:	e 5 🗆 Rasidence	B [] Out	(0	-			$\neg \neg$
	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT		CRIBE HOW IN	JURY OCCU	RED		
2	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI		RK? 'ES 2 NO	. A					- 1
- 48	3 Suicide 6 Could not be	26s. PLACE OF INJURY building, etc. (Speci	— A1 home, farm, atr	eet, factory, office	1	28f. LOCA	ATION (Street and or Town, State)	d Number or	Aurel F	loute Number,	
#	4 Homicide detarmined					J.,	a lowit, clate)				
COMPLEIED		AN: To the best of my knowle									
	2 MEDICAL EXAMINER:	On the basis of examination	and/or investigation,	In my opinion, d	eath occured at the	lime, deta	and pleca, and	dua to the o	ause(a) and menner as st	lated.
	296. SIGNATURE AND TITLE OF CERTIFIER	10	1.0		29c. LICENSE NU	MBER		29d. DATE S	IGNED	(Month, Day, Year)	. 🗆
2	Jeffry D	de	740		D-45			D 05	5/	19/95	
	NATIONAL NAVAL MEDICAL CENTER										
	JEFFREY B COLE, I	CDR MC US		10	<u>BETHESDA</u>	MD 2	20889-5	600_			\dashv
	MAY 2 4 1995	a development	M								



2, 3 shou	OR	90. FACILITY NAME (If not institution, give street and number) NOTH ARVAGE HOSPITAL			96. CIT	en
. Pages 1,	DIRECTOR	100. STATE 100. COUNTY MD Anne Arundel			v, rown ent	
n. ansit permit.	FUNERAL	10a. STREET AND NUMBER 478 Rita Drive				1
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 XMarried 3 Widowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 FORCES? 1 FYES, GIVE WAR	YES 2	KNO	13.	WAS DE
21215 al or attend for use as	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	\dashv	(Give kind of a	work done se retired.)	durina n
AND the hospit detached	COMPLETED	17. FATNER'S NAME (First, Middle, Lest)	P	ainte	Т	l-
MARYL retained by t 5 should be notified at	TO BE	Michael Knorz 196. INFORMANT'S NAME (Type/Print) Margaret B. Knorz	-	19b. MAILING 478		
IORE, N e 6 may be re ector, page 5 must be no		20e. METHOD OF DISPOSITION 1 GABurial 2 Cremetion 3 Removal from State	cemeler	ACE AND DATE (OF DISPO	SITION (I
ALTIN leath. Pag funeral dir xaminer		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	/ [HII	.lcres	22.	eme NAME
ORDS, P.O. BOX 68760 that the death certificate be executed withing thousant ed by the attending physician and completely filled in by th and Mental Hygiene prior to burial, cremation, or remoany injury, or other traumatic event, the medical	MEDICAL CERTIFICATION	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	on each ST/V AS A COL A	NSEQUENCE OF	POATE	1
日 田 田 多 名	BY PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUS 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26. F VOutpatien URY (bar)	PLACE OF DEAT	OTHE: 4 Nui BE OF	FR: raing No 28c. IN W
로로	COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of axam				
TO THE HOSPI TO THE FUNEF Be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	OF DEATH	(ITEM 27) (Type,	1/	
4		31. DATE FILED (Month, Day, Your) MAY 2 4 1995 July 2014	GNATU	301	! Ho	59 ()

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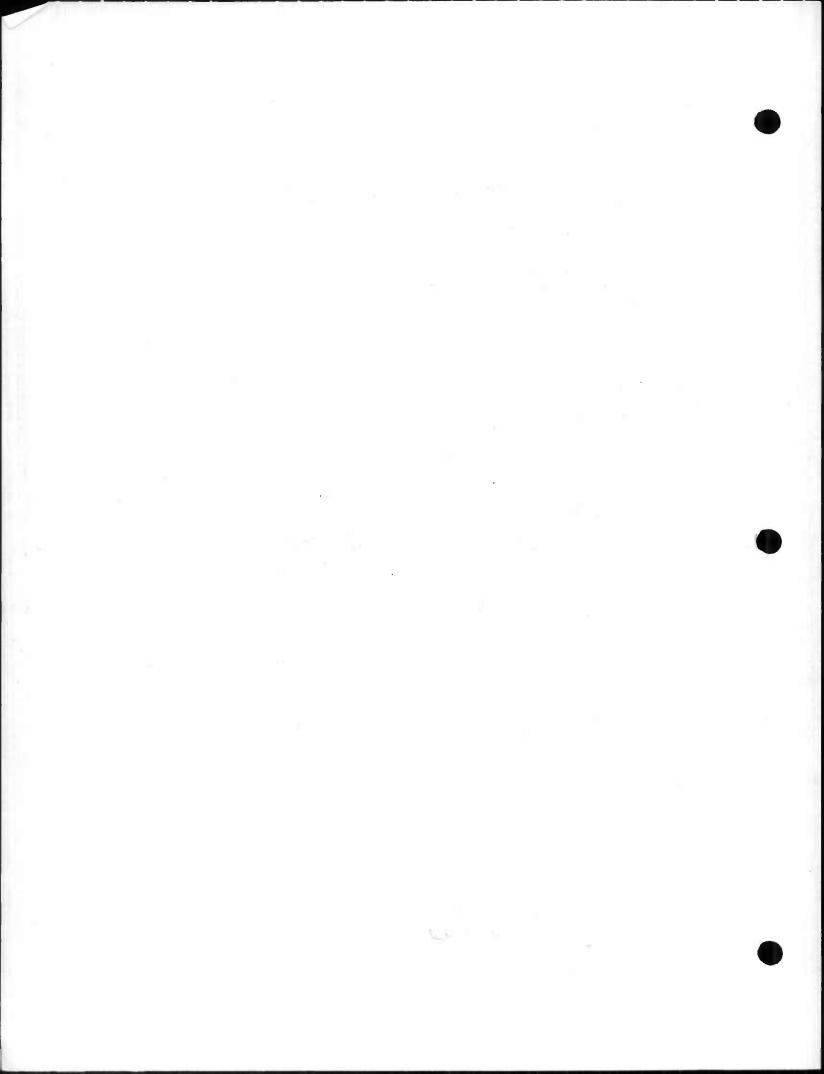
YRS.

1. DECEDEN

4. SOCIAL SECURITY NUMBER

577-58-4835 A

95 15827 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH 141 7. DATE OF BIRTH (Month, Day, Year 12-28 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign Country) MONTHS HOURS Germany OR LOCATION OF DEATH 9c. COUNTY OF DEATH Burnie ATION 10d. INSIDE CITY LIMITS? YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 21113 ECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—specify Cuben, Mexican, Puerto Rican, etc.)
ES 2 __NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: White TION most of working 16b. KIND OF BUSINESS/INDUSTRY Construction 18. MOTNER'S NAME (First, Middle, Maiden Surpame)
Kuni Gunda Kobrich of and Number or Rural Route Number, City or Town, State, Zip Code) Name of 20c. LOCATION — City or Town, State OATE 5/19 Annapolis, MD etery AND ADDRESS OF FACILITY desty Funeral Home, P.A. Ridgely Ave. Annapolis, MD node of dying, such as cardisc or respiratory arrest, App 21401 Approximats interval Between Onset and Death Failure weeks Disease (Lans 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? ng cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO 1 YES 2 NO UNCERTAIN . me 5 - Residence 6 - Other (Specify) JURY AT 28d. DESCRIBE HOW INJURY OCCURED YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) is and place, and due to the cause(s) and manner as stated. death occured at the time, data and place, and due to the cause(s) and manner as stated.



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floor steer death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Deot. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

permit. Pages 1, 2, 3 should

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	FOR STATE REGISTRAR	S	STATE OF MA		/ DEPAR					IENTAL HYGI REG.			/
	1. DECEDENT'S NAME (First, Middle,				17					2. DATE OF DEAT			3. TIME OF DEATH
	CATHERINE	3()	EANET	TE	KLI	NGM	EY	ER		MAY	7 1Q	95	2500
	4. SOCIAL SECURITY NUMBER	_		8. AGE (In yrs. I		IF UNDER		# UNDER	24 MDG	7. DATE OF BIRTH		_	HPLACE (State or Foreign
	213-28-3730		□ M 2 V F	62	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Yes	1027	Cour	try),
										FEB 15, 1933			rginia
	9a. FACILITY NAME (If not institution,					9b. CITY,	TOWN O	R LOCATIO	ON OF DEA				DEATH
1 6	12850 Sand	DOL	LAR WAY CHASE						I B	ALT	IMORE		
СТОВ	RESIDENCE OF DECEDER												
DIRE	Activities to the second secon	YTHUC	1			Y, TOWN O							tod. INSIDE CITY LIMITS?
<u>a</u>	Md.	balt	rimore		IPA	SAD	EN	A					1 YES 2 NO
7	10e. STREET AND NUMBER	20 0	l	The .			101.	ZIP CODE			10g. C	TIZEN OF	WHAT COUNTRY?
2	Joseph Chedry)20 C	hestnut	raven	CE.			21	226			USA	
FUNERAL	11. MARITAL STATUS					1			- 40				
5	1 Never Married 2 Married		FORCES? 1	YES 2	NO	13. W	WAS DECI	ENDENT O	F HISPANIC 1, Mexican,	C ORIGIN? (Specific Puerto Rican, etc.)	Yes or No —	14. RAC Bla	CE — American Indian, ck, White, etc.
B	3 Wildowed 4 Divorced	·	IF YES, GIVE WAI	R OR DATES		1	YES	2 NO	Specify:			Spe	city:
			-										HITE
LED	15. DECEDENT' (Specify only highes	'S EOUCATION grade comp	ON opieted)		Give kind of	work done di	CUPATIO luring mos	N st of workin	a	16b. KIND OF	BUSINESS/II	NDUSTRY	
iii I	Elementary/Secondary (0-12)	C	ollege (1-4 or 5+)		ite. Do NOT us	4				FEDS	-00-	2	serve
를	12				BANK	UNG				1606	= KXL	1165	SCIVE
COMPLET	17. FATHER'S NAME (First, Middle, La	est)						18. MOTH	ER'S NAMI	E (First, Middle, Ma	iden Surname,		
	Kichard	Tou	HY						HUB	Y THO	MAS		
BE	19a, INFORMANT'S NAME (Type/Print	t)			19b. MAILING	ADORESS	(Street a)			oute Number, City or			
일	Kevin Walt	0.00	has			50							1220
	20s, METHOD OF DISPOSITION	JICC	riei	1 000 00 40					CCI VV				
	1 Burial 2 Cremation 3		from State	cemetery, c	E AND DATE	ther place)	TION(Ne	me or		157	LOCATION -		
	4 Donation 5 Other (Specify			MARI	crematory or o					120/95 10	EKYIII	e N	1d
	21. SIGNATURE OF FUNERAL SERV	ICE LICENO	HEE.										
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	Kyson t. Cas). Q	Traver			(-	0.00	0		C MARIO	ries	Md.	21234
	23 PART L Frier the disease). Q	yours	chused the	death Do	EV	sns 800	CHA Ha	rford	Rd, 8	bulto.	Md.	21234
	23. PART I. Enter the disease shock, or heert fe	a, or comp	plications that	caused the c	death. Do i	EV	sns 800	CHA Ha	rford	Rd, 8	bulto.	Md.	21234
	immediate cause (Final	a, or compiliure. List	plications that	caused the ce on each like	death. Do s	EV	sns 800	CHA Ha	rford	Rd, 8	bulto.	Md.	Approximate
	ahock, or heert fe	a, or compiliure. List	plications that	caused the ce on each like	death. Do i	EV	sns 800	CHA Ha	rford	Rd, 8	bulto.	Md.	Approximate Interval Between
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED (1) OF DEATH (ITEM 27) (Typo, Print)

DR. Charles Schiffer 225. Greene St. Balto. Md. 21202

31. DATE FILEO (Month, Day, Year)

MAY 2 4 1995

June of May 2 1995 DR. Charles Sch 31. DATE FILED (MONTH) DEN YEAR) MAY 2 4 1995

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heart of least. Page 6 may be retained by the hospital or attending physician.

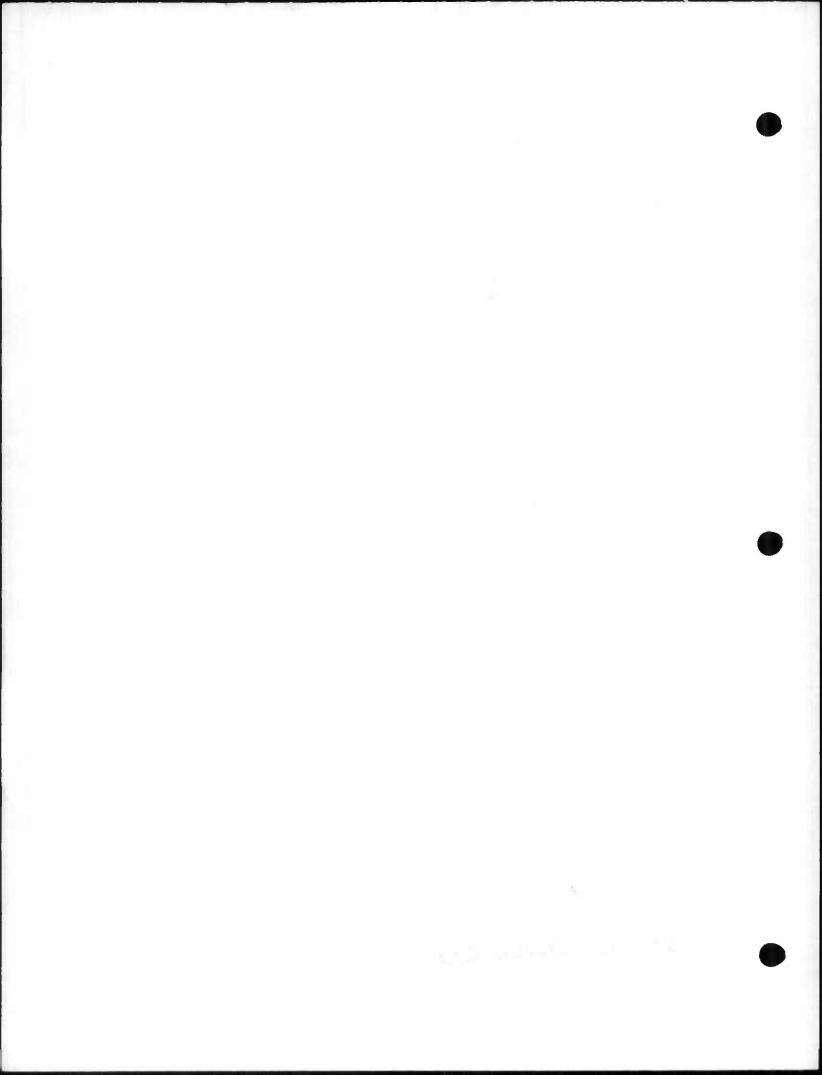
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								E OF DEATH		T	3. TIME OF DEATH
- 4	WILLIAM	Martin	LOES	CH, SR.					100	May 22, 1995			11:25 P. M
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	8. AGE (In yrs. la	al birthday)			IF UNDER 24 HRS.	7. DAT	E OF BIRTH	- 1	BIRTH	PLACE (State or Foreign
	212-12-0699		1 🔀 M 2 🗌 F	74	YRS.	MONTHS	DAYS	HOURS MIN.		oth, Day, Year) ch 16, 19	921	Mar	yland
	9a. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATION OF		011 203 21		NTY OF DE	
DIRECTOR	Stella Ma		spice				Tows	on			ba	lltim	ore
티	RESIDENCE OF DEC	10b. COUNTY	v		I 40- 017	Y, TOWN (201000						
E	Maryland	loa. Coon i	N/A		1			TION				- 1	10d. INSIDE CITY LIMITS?
7	10e. STREET AND NUMBER		11/73		Baltimore 101. ZIP CODE					10g. CITIZEN OF			1 X YES 2 NO
A	3135 Chesley Avenue					21234				United			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.							ANIC ORIG				- American Indian,	
	1 Never Married 2 Merried FORCES? 1 X YES IF YES, GIVE WAR OR DA				2 NO If yes,			s, specify Cuben, Mexican, Puerto Rican, etc.) YES 2 X NO Specify:			01 110-	Black, Specify	White, atc.
ВУ	3 Widowed 4 Dive	erced	WW II					z (M mo obse	Aty.			Specify	White
COMPLETED		EDENT'S EDU		(0	ECEDENT'S	work done	during mo	ON ost of working	10	Sb. KIND OF BUS	SINESS/INC	DUSTRY	
Ë	Elementary/Secondary (6)-12)	Coilege (1-4 or 5	Die Control	. Do NOT u	se retired.)	nn -						
M	12	Marie I v II			Mat	e				Tug I		5	
8		17. FATHER'S NAME (First, Middle, Last) John H. Loesch						18. MOTNER'S N					
B	19n. INFORMANT'S NAME (1		11	10	b MAII INC	ADDRES	0 (00	nell!		a Hambi		4.12	
2	DESCRIPTION OF THE PARTY	Mrs. Mary B. Loesch						ey Avenu		Baltimo			21234
	20a. METHOD OF DISPOSIT	ION		20b. PLACE	_							City or Tow	
	1 X Buriel 2 Crematic	(Specify)		Dayle	emetory or o	ther place!			1			nore, Maryland	
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE Mark	T. Zavo	vna	22.	NAME A	ND ADDRESS OF F	ACILITY		CT CTIII	01 0,	nar y rand
	> mara	27.	201000	1. 2410	Jina			ard J. F Harford			4 i ma.	. M	d. 21214
	23. PART I. Enter the d	iseeses, or c	omplications tha	t ceused the de	eath. Do i								Approximata
	enock, or n	esit laliura.	List only one cau	se on each line	h.								intarval Between
	IMMEDIATE CAUSE (Finel disease or condition)												
ł	disease or condition resulting in desth) a. Stoman Cancer / Lung Cancer. 6 month Due to (or as a consequence of):												
Z	Sequentially list conditions,												
ĔI	If any, leading to Imme- cause. Enter UNDERLY	diete	DUE TO	(OR AS A CONSE	OUENCE O	F):							
5	CAUSE (Disease or Inju		c. DUF TO	(OR AS A CONSE	OHENCE O	n.							
CERTIFICATION	thet initiated events resulting in death) LAS	т 📗	502 10	(On AS A CONSE	OUENCE O	r).							j
CE		d											
MEDICAL	PART II. Other aignifice	nt condition	s contributing to	deeth but not i	resulting	In the un	deriyin	g ceuse given in	n Part I.	24s. WAS AN			WERE AUTOPSY FINDINGS
ä										1 - YES 2	No		COMPLETION OF CAUSE OF DEATH?
Σ											/	1 .	T YES 2 NO
ä	DID TOBACCO U		RIBUTE TO CA					UNCERTA	IN X				44
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		E OF DEA	OTHER							
₹	1 YES 2 NO		1 Inpatient 2	-	-		_	ne 5 🗆 Residence			lospi		
	1 Natural 5	Pending	(Month, D.		28b. TIM	URY	WC	JURY AT ORK? YES 2 NO	28d. Di	ESCRIBE HOW IN	JURY OC	CURED	
B	2 Culette	Investigation	28e. PLACE O	INJUNY — At ho	ome, term,	Rreet, fact			281 1.0	CATION (Street a	nd Mumber	or Pural Bo	uto Alumbas
	_ 。 _	Could not be determined		etc. (Special)			.,,		Cit	y or Town, State)	no reamber	or norer no	ore regimosi,
۳	29s. CERTIFIER	IFYING PHYSIC	CIAN: To the best of	Wagning of	eth occurs	ad at the t	lone dete	and plans and di-	a de the d		Yala Ba		
COMPLETED													and manner as stated.
	2 MEDICAL EXAMINER: On the basis of assemination and/or inve							29c. LICENSE ME					Month, Day, Year)
BE								1/15	584			73.	
임	30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)							
	DR. EDDIE N	AKHUDA	2300 D	ULANEY '	VALLE	Y RD)., [TOWSON,	MD	21204			
	31, DATE FILED (Month, Day,			R'S SIGNATURE									
	MAY 2 4 199	5 July	Mules	0									
		- //		Marke II									



1995

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: White

1 X YES 2 NO

Mary land

N/A

U.S.A.

7;30 P. w

Pages 1, 2, 3 should

permit.

page 5 should be detached for use as the burial-transit

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

notified at

8

must director,

examiner

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

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	hour	Pa o	E
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5	rithin	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi - be filed within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burlal, cremation, or removal.	ant,
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH May William Henry McCawley 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) June 11,1908 IF UNDER 24 HRS. IF UNDER 1 YEAR 1 💢 M 2 🗌 F 86 DAYS HOURS MIN. 220-03-1337 VBQ 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2805 Strathmore Ave. Baltimore RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland N/A Baltimore 10s. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2805 Strathmore Ave. 21214 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)
1 ☐ YES 2 ☒ NO Specify: 1 Never Merried 2 Married 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Milk Man Cloverland Dairy 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Joseph McCawley Coral Taylor 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M Raker 4228 Darleigh Rd. 21236 20e. METHOD OF DISPOSITION
1 A Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE MoreTand Mell: Park 5/24/95 4 Donation 6 Other (Specify) Balto. Md. 21. SIGNATURE OF FUNERAL SERVICE LICES 22.NAME AND ADDRESS OF EACHTY FUNERAL HOME. Inc. 1 ondel 5305 Harford Rd. Balto. Md. 21214 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haert fallure. List only one cause on each line. BDOMINAL IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN

1 Inpetient 2 ER/Outpetient 3 DOA

28e. DATE OF INJURY (Month, Day, Yeer)

24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2

261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO

Approximate

intervai Betw

Onset and Death

25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:

OTHER:

OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 26d, DESCRIBE HOW INJURY OCCURED

28c. INJURY AT WORK? 1 YES 2 NO 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. (Check only one)

26b. TIME OF

м

2 MEDICAL EXAMINER: On the beels and/or investigation, in my opinion, death occured at the time, date end piece, and due to the ceuse(s) and menner se stated. 29d. DATE SIGNED (Month, Day, Year)

5 2 2 95 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edward P. Costlow M.D. 10 Gerard Ave. 21093 31. DATE FILED (Month, Day, Year)

2 4 1995

27. MANNER OF DEATH

5 Pending

6 Could not be

Investigation

determined

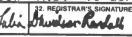
Mari

1 Natural

2 Accident

3 Sulcide

4 Homicide

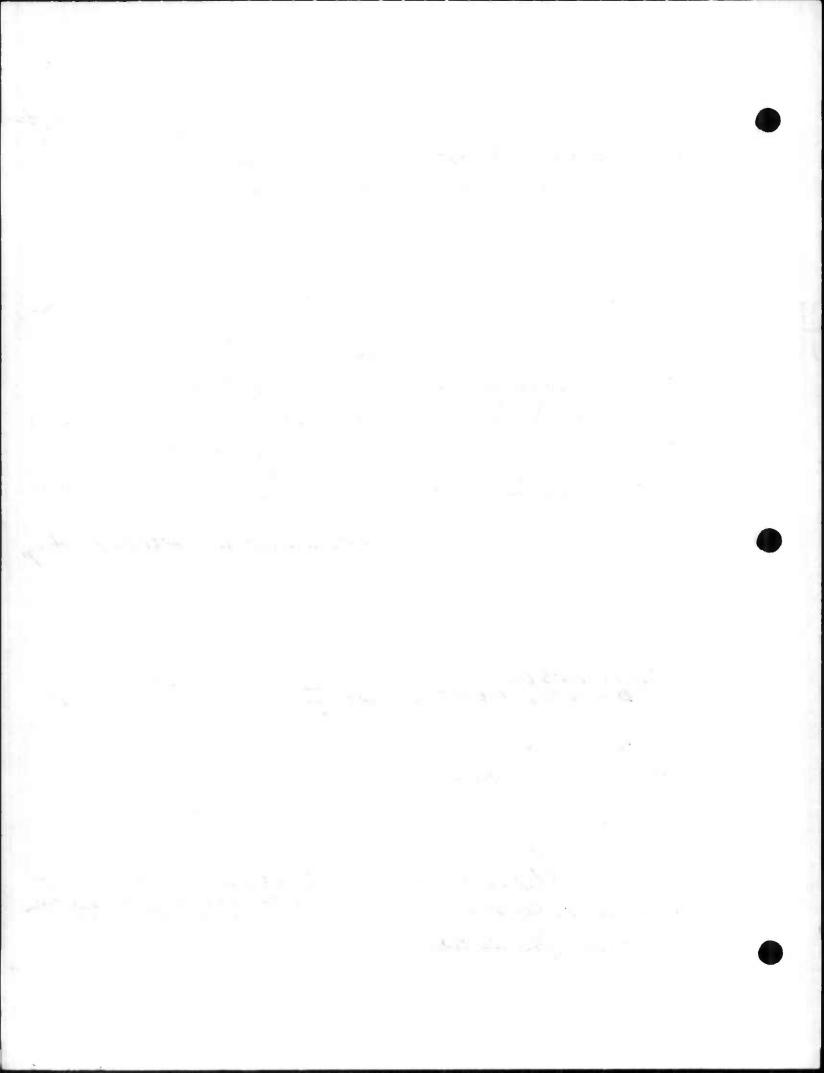


who o' o' a special

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MALCOLM GERAL 12 DINE 9 MAY 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Fo -28-3240 108 58 1 - M 2 XF YRS Pages 1, 2, 3 should 90. FACILITY NAME (# not 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTHWEST INDRE mole 10 RESIDENCE OF DECEDENT 10e. STATE 10b. COURT Flown OR LOCATION 10c. CITY 10d. INSIDE CITY LIMITS? MS 20 40 70 1 TES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? A the funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married If yes, specify Cubs Black BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) oppin State College (14 or 5+) Clerk A 18. MOTHER'S NAME (First, Middle, Maiden Surni notified at BE 00 70 NE 19b. MAILING ADDRESS (Stre 2 ra WIA 112 21117 ams 9 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of gemetery, crematory excited place) DATE 200 must Md Buriel 2 Cremetion 3 Re nation 6 Other (Specify) medical examiner BLOF FUNERAL SERVICE LICENSES AME AND ADDRES O hours after death. ta. 4d 21215 4300 alpa 23. PART I. Enter the dige ses, or complications that coused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, and completely filled in by burial, cremation, or remo Approximats interval Between shock, or hear fellure. List only one cause on each lins. IMMEDIATE CAUSE (Finsi Onset and Death the disesse or condition CEREBROVAS CULLAR ACULE resulting in desth) other traumatic event, law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentislly list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury OUE TO (OR AS A CONSEQUENCE OF) that initisted events resulting in desth) LAST 6 any injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY, PERFORMED? signed by to Health and Hypertonsion 1 | YES 2 | NO OF DEATH? me 11/tus DIABETUS CHIPE 1 TES 2 NO certificate has been in the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO LY UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Tem **EXAMINER?** OTHER HOSPITAL OR ATTENDING PHYSICIAN: 1 TYES 2 THO 1 Empetient 2 ER/Oulpetient 3 DOA ome 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY with t 28b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death w BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 50 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED e Could not be 4 Homicide 28 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my lo dge, death occurred at the time, date and place, and due to the cause(e) end menner as stated. TO THE HOSPITAL OF THE FUNERAL D be filed within 72 he IMPORTANT: If IN 2 MEDICAL EXAMINER: Or investigation, in my opinion, death occured at the time, date and piece, end due to the cause(s) and menner as stated. 286. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 188 KUD 2 30. NAME AND ADDRESS OF PERSON WHO CO ETED CAUSE OF DEATH (ITEM 27) (Type, Print) CE TOO CONANAN ORLHNDO Rud 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

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S	e e	cian	ior to	2000
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the I	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deta	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT if item 28 is marked or item 23 shows any injury or other fraumatic event the medical evantines must be notified at one
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	ITEM: 28f, PER D	R. FILM G-72	3 5/24/95	i t.t					95	15832
	1 - FOR STATE REGISTRAR	STATE OF MA			TMENT OF			NTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH		3. TIME OF DEATN
	WILLIAM	R. MIT	CHELL					05 1	4	95 9:30A N
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. less	t birthday)	IF UNDER 1 YEA			DATE OF BIRTH (Month, Day, Year)		8. BIRTNPLACE (State or Foreign Country)
	241-40-5812	1× M 2 🗆 F	62	YRS.	MONTHS DAY	HOURS	MIN.	03-03-3	3	NC .
	9a. FACILITY NAME (If not institution, give	street and number)			96. CITY, TOW	OR LOCATE	ON OF DEATH			ITY OF DEATN
l e	ST. JAMES TE	ERRACE AF	T.		BALTI	MORE		N/A		
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	~			Y, TOWN OR LO					
I E								10d. INSIDE CITY LIMITS?		
	MD N/A BALTIMORE 10e, STREET AND NUMBER									1 X YES 2 NO
FUNERAL	827 N. ARLINGTON AVE. 21217									ZEN OF WHAT COUNTRY?
W	11. MARITAL STATUS	12. WAS DECEDENT		MED	142 490 5			ORIGIN? (Specify Yes		SA
	Never Married 2 Merried	YES 2 TH	10	If yes,	specify Cube	n. Mexicen. P	verto Rican, atc.)	or No-	 RACE — American Indian, Black, White, etc. 	
B√	3 Widowed 4 Divorced	ON DATES		''''	ER S MI MO	Specify:			Specify: BLACK	
8	15. DECEDENT'S EDU (Specify only highest grade	CATION	16e, DE0	CEDENT'S	USUAL OCCUPA	TION		166, KIND OF BUS	INESS/INDL	USTRY
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	se retired.)	HOSE OF WORKIN	g			
N P	5th		P:	IPE	TITTER			UNK		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							(First, Middle, Melden	Sumeme)	
6 111	UNK									
TO BE	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	MATTIE LEE COOK 700 N. CARROLTON AVE. BALTO. MD. 21217 20s. METHOD OF DISPOSITION DATE 20s. LOCATION — City of Town, State									
TERRET	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Rem	loval from State	complex. com		the example and			DATE 20c. LOC		•
	4 Donation 5 Other (Specify)	enters.	WEST	ERN	STAR	CEM.	05-1	9-95 B	ALTI	MORE, MD.
examiner	21. MONATURE OF PURENCE DESIGNED OF	, ense					S OF FACILI	YLIE F/	u Da	
	1//////			_	63	TA C	CILM	OD CODE	TP/ID	21217
200	23. PART LEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.									
	IMMEDIATE CAUSE (Fine)	-								interval Between Onset and Deeth
m, me menca	disease or condition resulting in death)	a. COPD DUE TO (O	SEVE	120	(O2+	Heu	rd de	reallyt		
200										
N N	Sequentially list conditions,	b. Pegy a	PRESI.							
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	due to (o	A AS A CONSEO	UENCE O	F):					
	CAUSE (Diseese Dr injury	c. 175P.	R AS A CONSEO	HENCE OF						
RTI	that initiated events resulting in death) LAST	DM.	H AS A CONSEO	UENCE O	-):					
		d								
3.1	PART II. Other algnificent condition	na contributing to de	eth but not re	sulting	n the underly	ng ceuse g	iven in Par			24b. WERE AUTOPSY FINDINGS
MEDICAL								PERFORI		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME										1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAU	SE OF DEAT	ГН ҮЕ	S NO	UNC	ERTAIN [
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11000	26. PLACE	E OF DEAT	N (Check only or	9)				
LS.	1 TYES 2 NO	HOSPITAL:	R/Outpetlant 3	□ DOA	OTHER: 4 Nursing H	me 5 Re	eldence 6	Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF IN. (Month, Day,	JURY Year)	28b, TIM		JURY AT	26	d. DESCRIBE HOW IN	JURY OCCU	URED
B	1 Natural 5 Pending 2 Accident Investigation	non-	9	no	44		2 □ NO N.M.			
	3 Suicide 8 Could not be	28e. PLACE OF II building, etc	NJURY — At hon (Specify)	ne, term, s	treet, tectory, of	loe	261	LOCATION (Street at City or Town, State)	nd Number o	or Rural Route Number,
COMPLETED	4 Homicide determined		no	n-e				00	809	3
1		ICIAN: To the best of my								
OM										cause(s) end manner as stated.
E W	29b. SIGNATURE AND TITLE OF CERTIFIE	R				29c. LICE	NSE NUMBER	1	29d. DATE	SIGNED (Month, Day, Year)
0 8	moreen an	3				D	6809	3	1:5	716/95
IFI	30. NAME AND AGORESS OF PERSON WH	O COMPLETED CAUSE	OF OEATN (ITEM	27) (Type,	Print)		0.01			1(/)

BALTO. MD.

21213

MARGUERITE MORAN 3400 BREHMS LN.

31. DATE FILED (Morith, Day, Year)

MAY 24 1995

Malessa A.P.A. Iggilas reg

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 995 15 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign -1853 58 1 M 2 - F JOTH Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH manor DIRECTOR Pleasant Y TIMORE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore 1 YES 2 NO ano permit. FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21213 the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. 600)5A OW Page 6 may be retained by the hospital or attending physician. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 ВУ Specify: 3 Widowed 4 Divorced -12-57 14-55 ack COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION ecify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Laborer aracle 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME NILMER 76 MOODY BE 2000 notified 2 2 Burlel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of must Donation 8 - Other (Specify) medical examiner 22. NAME AND ADDRESS OF FACILITY 5 21. SIGNATURE OF FUNERAL SERVICE LICENSE hours after death. turns 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or Approximate shock, or hasrt fallure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition ARCINOMA event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequantisity list conditions, if sny, landing to immediata the death certificate be cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY been signed by the control of Health and I shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN has be OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) this certificate h HOSPITAL OTHER 4 Nursi 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 6 rsing Home 5 - Residence 8 - Other (Specify) 27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO After the BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 50 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 8 Could not be 28 4 Homicide Hem 29a. CERTIFIER TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 h 2 MEDICAL EXAMINER: On 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 2 30, NAME AND ADDR WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

REGISTRAR'S SIGNATURE

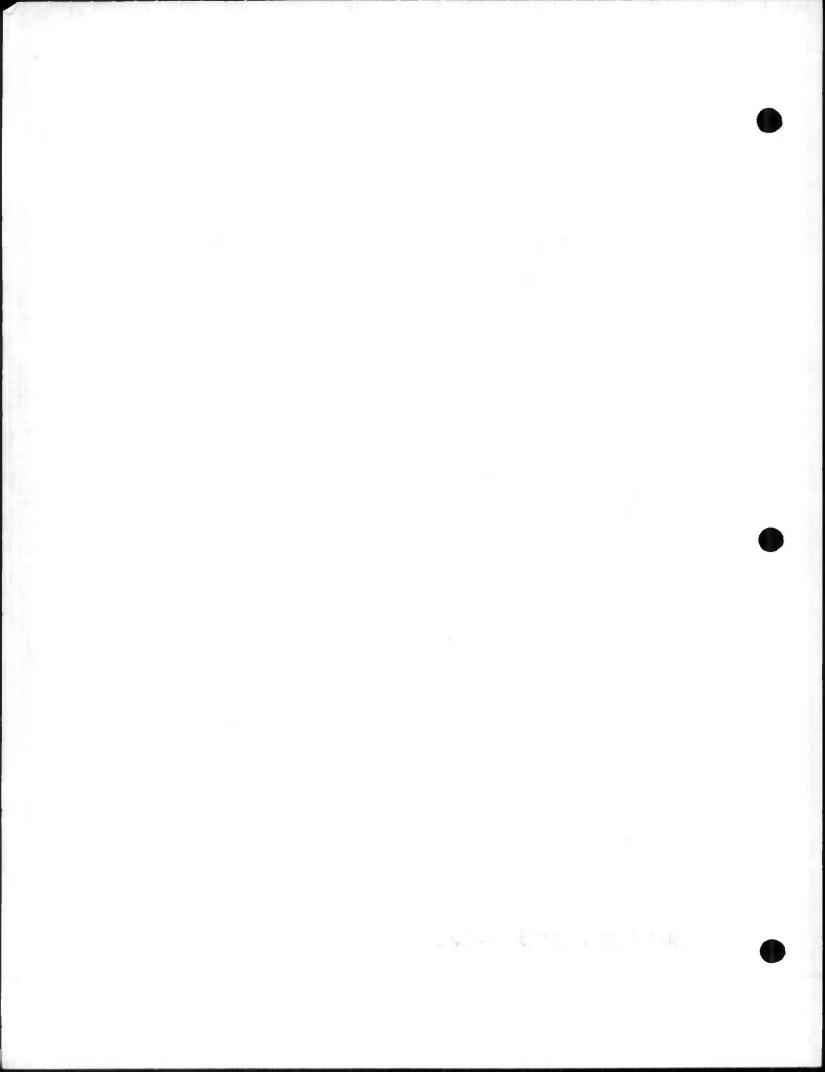
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		1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Lest) RONALD 4. SOCIAL SECURITY NUMBER	M F	7 S O /	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEATH MONTH Z	0 1995	741207
pinous		452-90-6683 9e. FACILITY NAME (if not institution, give so	1 Å M 2 ☐ F		MONTHS DAYS	HOURS MIN.	Dec. 29,	1951	THPLACE (State or Foreign intry) Texas
1, 2, 3 shd	TOR	11/4 / 4 5	General Hosp	oital		on Location of D umbia	EATH	9c. COUNTY OF	
Pages	DIRECTOR	Maryland 106. COUNTY	Howard	10c, CITY	TOWN OR LOCAT			10d. INSIDE CITY LIMITS? 1 YES 2XXNO	
in. ransit permit,	FUNERAL	9024 Queen Maria	Court	101. ZIP CODE 21 (5		S.A.
D 21215-0020 pital or attending physician. ed for use as the bunal-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 MDIvorced	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES IF YES, GIVE WAR OR DATE	2 NO If yes, specify Cuben, Mexic			nn, Puerto Rican, etc.)	RACE - American Indian, Black, White, etc. Specify: Black	
	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of wi		ON st of working		SINESS/INDUSTRY	
AND 2 the hospital detached to	once.	17. FATHER'S NAME (First, Middle, Last)	Social	Worker		State Government AME (First, Middle, Meiden Surname)			
ALTIMORE, MARN feath. Page 6 may be retained to funeral director, page 5 should xaminer must be notified	m ا	Unknown 19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	Annie J	Route Number, City or Tow	rn, State, Zip Code)	7.04045	
	9	Maureen Kenny 20e. METHOD OF DISPOSITION 1 1 1 1 1 1 1 1 1 1	val from State	ACE AND DATE OF	F DISPOSITION (Na	me of O.A.	t Columbia	CATION - City or	
		4 Donation 5 Other (Specify)	Mar	yland V	eterans 22. NAME AN Leroy	Cémeter D ADDRESS OF FA M & Rus	y Cro count sell C Wit	zke Fune	
within 24 hours after displaying the cremation, or removal.	event, the medical	23. PART i. Enver the diseases, or coshock, or heart feliure. LIMMEDIATE CAUSE (Final	CARDIAC	ilne.	ot enter the mo	de of dying, suc		iratory erreat,	Approximate Interval Between Onset and Death IMMEDIAN
Co. BOX 687 certificate be executed nding physician and cor Hygiene prior to burial.	y, or other traumatic eve	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	DISEQUENCE OF	WG-J	TANDI	VG- PO DIOMYO	ST-VIR	AL Y 5 YRS 34 HRS
w requires that the been signed by the r. of Health and M.	MEDICAL	PART II. Other algnificent conditions ACUTE REAL LACTIC ACI DID TOBACCO USE CONTR	IAL FAIL	-URE	SOLVE	ceuse given in	PERFOR	RMED?	Ab. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
The The ate D	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	OTHER:		8 Other (Specify)		
PHYSICIAN: or this certifical th with the St	marked, or BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJI		28d. DESCRIBE HOW I	NJURY OCCURED	
	28 is	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, atc. (Specify)	At home, lerm, st	rest, factory, office		281. LOCATION (Street City or Town, State)		I Route Number,
2 k k	를 를		IAN: To the best of my knowledge: On the beals of examination ar						o(e) and menner se stated.
불뿔	TO BE COI	296. SGNATURE AND TITLE OF CERTIFIER	onan	M	0	D343		_	ED (Month, Day, Year) 1 20 P195
-041		30. MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	AN,	2/2/	VOLL	N. DR.	Count	MBVA MD
		31. DATE FILED (Month, Day, Year) MAY-2 4-19019 945	32. REGISTRAR'S SIGNATU	RE			***************************************		



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		HEGISTHAR		CERTIF	ICATE	JE DEATH	REG. NO) <u> </u>	
		1. DECEDENT'S NAME (First, Middle, Last)		- 1			2. DATE OF DEATH MONTH D	MAY YE	3. TIME OF DEATH
Y			25 H932	Kin			MAY 13		4:30P.M.
		4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthdey)	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year)	8.1	BIRTHPLACE (State or Foreign Country)
Pi		alb 3a 1a'1'1		Sq YAS.			F184 193	3P L	SARYLAND
binould		9a. FACILITY NAME (If not institution, give s.	reet and number)			VN OR LOCATION OF DI		9c. COUNTY	
2,	СТОВ	RESIDENCE OF DECEDENT	URT		Lion	KEYSVILL	2	BAL	limore
es T	1 W I	10a. STATE 10b. COUNTY		10c. CI	Y, TOWN OR L	OCATION			10d. INSIDE CITY
. Pages	DIR	FLORIDA ME	ARion	5	imms	RFILLO			LIMITS?
permit.		10e. STREET AND NUMBER	11.		J1 11 12	101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
	ER/	JP 2.2 PHRTI	THI		1	34491		U	0.2
-0020 ing physician. the bunal-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS	DECENOENT OF HISPAI	NIC ORIGIN? (Specify Ye	s or No — 14.	RACE — American Indian,
ding physic the burial	BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YE	ES 2 NO ROATES		yes 2 NO Specify			Black, White, etc. Specify:
N 5 8			KORLA						STIKE
_ 5	ETED	15. DECEDENT'S EOUI (Specify only highest grade	completed)	18a. DECEOENT'S	work done durin	PATION g most of working	16b. KIND OF BU	ISINESS/INDUST	(RY
D 2 voital o	1 5	Elementary/Secondary (0-12)	College (1-4 or 5+)	II/o. Do NOT U	11.57		00	-	011
Z 2 2 5	COMPL	17. FATNER'S NAME (First, Middle, Last)		MANAI	<u> </u>	T se MOTHERIO NA	レナト		PHONE CO.
YLA by the be det	1 - 1	None Day	mck -	_		COO.	ME (First, Middle, Meiden	Sumame)	
	B	19a. INFORMANT'S NAME (Type/Print)	10 1511	19b. MAILING	AOORESS (Str	set and Number or Burel	Route Number, City or Tox	un State Zio Cox	rial
	2	Holin E nek	3	17840	5 5	TO HILL			
May be or, page		20a. METNOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITIO	V(Name of		RFILLO	
0 0 5 2		Surial 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crematory or		Michael el	15-22		\sim 1
TIMO		21. SIGNATURE OF FUNERAL SERVICE LIC		المارا المارات		E AND ADDRESS OF FA	CILITY = C)1	Devio	THE WAR
ALTIN death. Pag tuneral dir I.		1/20	. 1		EV	11 -1.	> -	1.00	
B/ rs after of n by the removal.	\vdash	23. PART I. Enter the disesses, or o	Jam /	and the death. De	332	YORK	1000-1	Mon	um
3		shock, or heert fellure.	Liet only one ceuse or	eech line.	not enter the	mode or dying, suc	n as cerdisc or resp	elratory srrest	interval Batween
# E E #		iMMEDIATE CAUSE (Final disease or condition	CAANITO	21 100 02/0	0.10	4 0 4			Onset and Dasth
ted within completely fille ial, cremation, event, the		resulting in death)	DUE TO (OR A Metastet	S A CONSECUENCE O	100	HUGESI			Smins.
P 8 8 3 8	-		Metastet	20 Eso	chage	cal Car	cinoma		18mos.
3 0 E	RTIFICATION	Sequentisity flat conditions, if any, leading to immediate	OUE TO (OR A	S A CONSEQUENCE O	F):				
ficate be physician ne prior to the prior to the prior to the traus	S	cause. Enter UNDERLYING	e						
certificate nding physie Hyglene pri	車	CAUSE (Disesse or injury thet initiated events	DUE TO (OR A	S A CONSEQUENCE O	F):				
O E SH S	E	resulting in death) LAST	d						
DS, P the death the atten d Mental H injury, o	CE	PART ii. Other algnificant condition	s contributing to deat	h but not resulting	In the under	Ving cause given in	Part i. 24a, WAS AN	LAUTOBEN	24b. WERE AUTOPSY FINDINGS
C # 5 8 >	CAL				THE WITE	ying couse given in	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
							1 TES	2 NO	OF DEATH?
REC w requires been sign it, of Heal	Σ	DID TORACCO LISE (CONTRIBUTE TO	CALISE OF	DEATH	VEC TO NO			1 TES 2 XNO
	AN	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	ONIKIBUTE TO	CAUSE OF		YES NO			
上 年 智 音	PHYSICI	EXAMINER? 1 YES X NO	HOSPITAL:	hytostlant 2 DOA	OTHER:				
D 9 55 -	H	27. MANNER OF DEATH	28e. DATE OF INJUR	-		Nome 5 Realdence	26d. DESCRIBE HOW	INJURY OCCUR	EO
NG PHYS (feer this ceath with marked		1 Netural 5 Pending Investigation	(Month, Day, Yea	ir) IN	JURY M 1	WORK?			
ION VDING I After r death	D BY	2 Accident Investigation 3 Suicida 6 Could not be	28e. PLACE OF INJU	JRY At home, term,	street, factory,	office	281. LOCATION (Street	and Number or F	Rural Route Number,
VIS MTTE	ш	4 Homicide determined	building, etc. (S	вреспу)			City or Town, State,)	
DIV OR A DIREC hours	PLET	29a. CERTIFIER 15 CERTIFYING PHYSI	CIAN: To the best of my kn	owledge, death occur	ed at the time	date and place, and due	to the cause(s) and ma	nner ee eleted	
	Σ								suse(a) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II	00	29b. SIGNATURE AND TITLE OF CERTIFIER			-	29c. LICENSE NUI			GNED (Month, Day, Year)
THE SECTION OF SECTION	B	1 cm	Sun 1)		DU31-	13	DATE SI	AVIO 190:
2 6 8 ₹	임	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	, Print)	7771		1 1	מחוף עח
(_		LAWNENCE	J. SCHA	0 1 1	76	05 DILE	n Bris	E TON	Yasus an, 4020
9		31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S						
		MAY 2 4 1995 A	he diwater he	weally					

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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 show with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-55 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the ibe filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

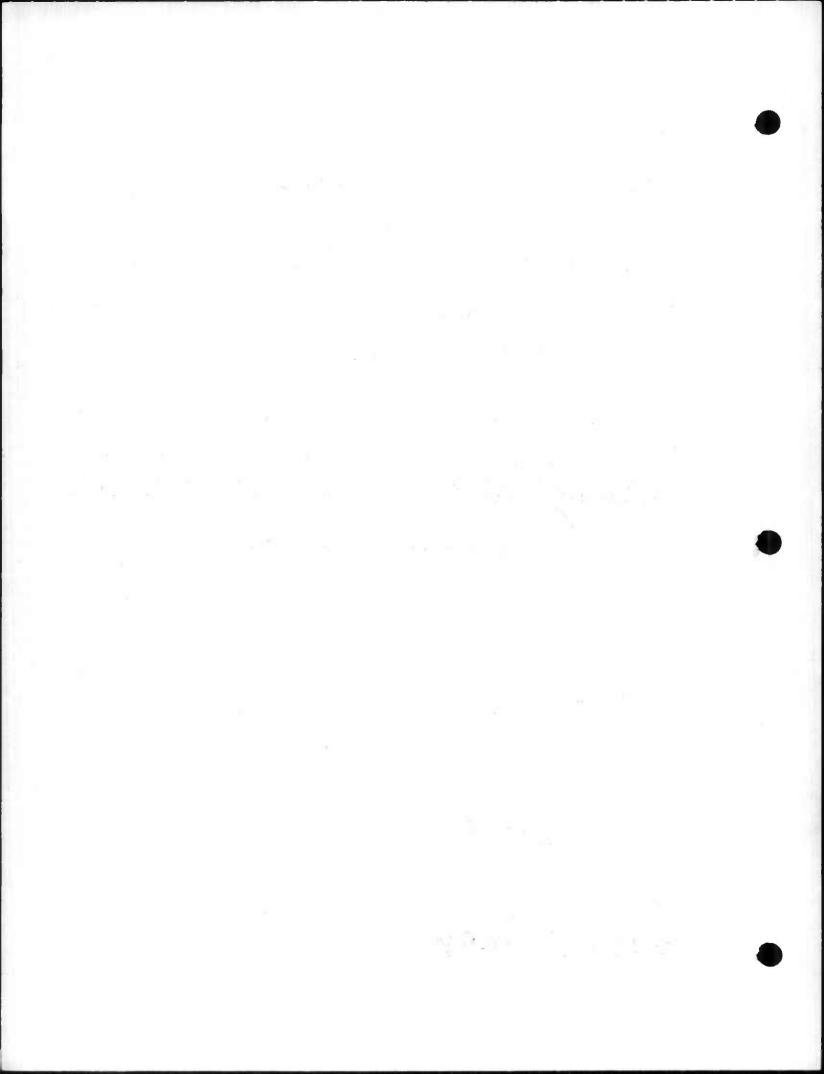
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	1 - FOR STATE REGISTRAR	STATE OF N		/ DEPAR						HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Li	est)							2. DATE OF		44		3. TIME OF DEA	ATN
	EDWARD				MIF	ROS			MAY	22	2 1	995	2:25	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	last birthday)		7	IF UNDER		7. DATE OF (Month, D			8. BIRTH Count	NPLACE (State or F	oreign
	218-10-3556	1 [X] M 2 □ F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	02/1		5	COUNT	MD	
	9e. FACILITY NAME (If not institution, g						OR LOCATIO					UNTY OF D	EATH	
9	246 S.CASTLE				BE	4T.T.T	MORE	2				N/I	A	
DIRECTOR	RESIDENCE OF DECEDENT			10c CIT	Y, TOWN	08 1 004	ION						10d. INSIDE CIT	
E	MD	N/A			alt:								LIMITS?	
	10a. STREET AND NUMBER		_		010.		ZIP CODE				100 00	TIZEN OF N	1 X YES 2 WHAT COUNTRY?	NO
FUNERAL	246 S. Cast:	1 p S+						231			iog. Cr	USA		
Ž	11. MARITAL STATUS		T EVER IN U.S. A	RMED	13	WAS DEC			IC ORIGIN?	Specify Ver	or No.			lla a
I	1 Never Married 2 Merried	12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W	X YES 2	NO		If yes, sp		. Mexice	n. Puerto Rice		01 110-		E — American Ind k, White, etc.	num,
ВУ	3 Widowed 4 Divorced	World W				I 🗌 TES	2 (VINO	Specify	7			Spec	White	,
	15. DECEDENT'S I	EDUCATION	16a. C	Give kind of	USUAL O	CCUPATIO	ON		16b. KI	ND OF BU	SINESS/IN	DUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5 +		le. Do NOT us	se retired.)	-	SI OF WORKING	,						
M	6	0		Jan:	itor					Fa	cto	ry		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						111		ME (First, Midd					
BE	Stanislous N	1iros							Fra					
0	19e. INFORMANT'S NAME (Type/Print)								loute Number,					
	Dr. Mejia					_		11a		7			ity, M	1D
	20a, METHOD OF DISPOSITION 1 MBurlel 2 Cremetion 3 - F	lemoval from State	cemetery, c	rematory or q	OF DISPOS	SITION (No	me of		1			- City or To		
	4 ☐ Donation 5 ☐ Other (Specify) _ 21. SIGNATURE OF FUNERAL SERVICE	Oceander.	Lou	remetory or o					5/25	Ba	alto	., [MD	
	/ Committee of the comm	The	1	7	22.		D ADDRES		Weber	Enry		1 11	2200	
	aland	1 In	Ny			401	S.	Che	ester	St	B	alto	omes o., MD	
	23. PART i. Enter the diseases,	or complications that re. List only one cau	coused the d	leath. Do r	not enter	the mo	de of dylr	ng, auch	aa cerdled	or reepl	ratory a	rrest,	Approxim	
	IMMEDIATE CAUSE (Final	100											Onset an	
	disease or condition resulting in death)	. Hyper	pensio	10	all	aro	sue.	rohi	- la	ard	iova	Ma	Cal	
	0.000	a. Hyper Jour To	OR AS A CONS	EOUENCE O	F):					0	Lise	ease		
N	Sequentially list conditions,	b												
ATI	If any, laeding to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSI	EOUENCE O	F):									
SE	CAUSE (Disease or injury that initiated events	c	OR AS A CONS	FOLIENCE OF	E)·						-		-	
CERTIFICATION	reaulting in death) LAST				,,								İ	
B		d											-	
AL	PART II. Other algoliticant condit	iona contributing to	deeth but not	resulting	in the ur	nderlying	ceuse g	iven in I	Part i. 24	a. WAS AN PERFOR		24b	. WERE AUTOPSY F	
음									_ 1	YES 2			COMPLETION OF OF DEATH?	
MEDICAL									_		•		1 YES 2	NO
ä	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DE	ATH YE	S 🗆 I	NO [UNC	RTAIN	1 E					
동	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PL/	CE OF DEAT										
PHYSICIAN:	1 TYES 2 NO	1 Inpatient 2	ER/Outpatient	3 DOA	OTHER		o 5 T Res	Idence	6 Other (S	pecify)				
Ŧ	27. MANNER OF DEATN	28e. DATE OF (Month, De	INJURY ly, Year)	28b, TIM	E OF	28c, INJ WO	URY AT RK?		28d. DESCR	IBE NOW I	NJURY OC	CURED		
BY	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 [NO						
	3 Suictde 6 Could not	building,	INJURY — At h	iome, ferm, e	street, fact	ory, office	•		28f. LOCATIO	ON (Street e	and Numbe	or or Rural F	Route Number,	
COMPLETED	4 Nomicide determined				<u> </u>									
길		IYSICIAN: To the beat of												
8	one) 2 MEDICAL EXAM	INER: On the beele of ex	amination end/or	r investigatio	n, In my o	pinion, d	eath occure	d at the t	time, date and	f place, en	d due to t	he cause(e) end menner ee i	stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIF	FIER	1				29c, LICE	ISE NUM	BER		29d, DAT	TE SIGNED	(Month, Day, Year)	
B		Man					0.0	. M.	ь.		► M	AY 2	23,1995	5

PENN STREET, BALTIMORE, MARYLAND 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

Down d R Fowler 111 PENN 111 P. REGISTRAR'S SIGNATURE



ORE, MARYLAND 21215-0020

DIVISION OF VITAL RECODES BO BOY 68760

BALLIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunat-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	medical examiner must be notified at once.	
CITIZEN OF VITAL RECORDS, F.O. BOX 867 60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TA hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

		CERTIF	ICATE OF	DEATH		AL HYGIEN REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)	0	372	1		2. DAT	E OF DEATH	W.	YEAR	3. TIME OF DEATH
	C.	Nico	Iay		Mar				11:28 P.
212 10 7222		rs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		E OF BIRTH		8. BIRTHI	PLACE (State or Foreign
		94 yrs.	MONTHS DATS	MOUNTS MIN.		. 17,19	00		vland
9a. FACILITY NAME (If not institution, give street	et and number)			OR LOCATION OF E	DEATH		9c. COUNT		
2632 West Park D	rive		Wo	odlawn			F	Balt	imore
-	albott	10c. CITY	Y, TOWN OR LOCA	odlawn					10d. INSIDE CITY LIMITS? 1 YES 2 NO
P.O. BOX 446			10	1. ZIP CODE 2166	3		10g. CITIZI		S.A.
11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	≥ NO	If yes, s	CENDENT OF HISPA pecity Cuban, Mexic 3 2 X NO Speci	an, Puerto	IN? (Specify Yes Ricen, etc.)	or No 1	I4. RACE Black, Specif	- American Indian, White, etc.
15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	a. DECEDENT'S (Give kind of w life. Do NOT us	USUAL OCCUPATI	ON ost of working	16	b. KIND OF BUS	INESS/INDU	STRY	
12	College (1-4 or 5+)	Home I				-	n Hon	ne	
17. FATHER'S NAME (First, Middle, Last) James Edward Col	liflower			18. MOTHER'S N. Sadie			Surname)		
196. INFORMANT'S NAME (Type/Print) James W. Nicolay	,	196. MAILING 2632	ADDRESS (Street	nd Number or Aural k Drive	Route Nur	odlawn.	Mary	ode)	d 21207
20a. METHOD OF DISPOSITION 1 XBurlet 2 Cremetton 3 Remove 4 Donatton 8 Other (Specify)	al from State 20b.PL.	ACE AND DATE O		une of	_	TE 20c. LOC	CATION — CI	ity or Tov	vn, Stata
21. SIGNATURE OF FUNERAL SERVICE LICEN		raine		NETERY ND ADDRESS OF FA		[WOOO	ırawn,	Mai	ryland
Lucossen	Dixle		Leroy	M & Rus	sell				al Home e Maryland
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Corry stes alliense	MSEQUENCE OF	Cano	any	ope	My lor.	Sec	ea:	Onset and De
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	are	2 .	un Væ	MU				
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of the cause of th	DUE TO (OR AS A CO	NSEQUENCE OF	n the underlyin	g cause given in	Part I.	24a. WAS AN / PERFORI	AUTOPSY MED?	24b.	
if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of the cause of the conditions of the cause	DUE TO (OR AS A CO	NSEOUENCE OF	n the underlyin	g cause given in	Part I.	24a. WAS AN / PERFORI	AUTOPSY MED?	24b.	WERE AUTOPSY FINDING ANALELE PRIOR TO COMPLETION OF CAUSE OF DEATH?
H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cond	DUE TO (OR AS A CO	DEATH YES	THER:	g cause given in	Part I.	24a. WAS AN / PERFORI	AUTOPSY MED?	24b.	WERE AUTOPSY FINDING AMPLETION OF CAUSE OF DEATH?
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H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the cond	DUE TO (OR AS A CO	DEATH YES DEATH YES PLACE OF DEATH At home, term, st a, death occurrent	The underlying of the underlyi	UNCERTAL DE 5 Passidence URY AT RES 2 NO solutions	8 Oth 28d. DE	24a. WAS AN / PERFORI 1 YES 2	AUTOPSY MED? NO NO NO NO NO NO NO NO NO N	24b.	WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PRO
H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cond	DUE TO (OR AS A CO	DEATH YES DEATH YES PLACE OF DEATH At home, term, st a, death occurrent	The underlying of the underlyi	UNCERTAL TO S Pasidence URY AT RK7 YES 2 NO and place, and due eath occurred at the	8 Oth 28d. DE 28t. LOC	24a. WAS AN / PERFORI 1 YES 2	AUTOPSY MED? AO AO AO AO AO AO AO AO AO A	24b. RED RED Coupe(s)	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AND ute Number, said menner as stated.
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST PART II. Other algnificant conditions of the con	DUE TO (OR AS A CO	DEATH YES DEATH YES PLACE OF DEATH At home, term, st a, death occurrent	The underlying of the underlyi	UNCERTAL DE 5 Passidence URY AT RES 2 NO solutions	8 Oth 28d. DE 28t. LOC	24a. WAS AN / PERFORI 1 YES 2	AUTOPSY MED? AO AO AO AO AO AO AO AO AO A	24b. RED RED Coupe(s)	WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PRO
H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the cond	DUE TO (OR AS A CO	NSEOUENCE OF NOT resulting is DEATH YE: PLACE OF DEATH 28b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b.	The underlying the un	UNCERTAL TO S Pasidence URY AT RK7 YES 2 NO and place, and due eath occurred at the	8 Oth 28d. DE 28t. LOC	24a. WAS AN / PERFORI 1 YES 2	AUTOPSY MED? AO AO AO AO AO AO AO AO AO A	24b. RED RED Coupe(s)	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO rute Number,
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other aignificant conditions of the conditions of the cause of the conditions of the cause	DUE TO (OR AS A CO	NSEOUENCE OF NOT resulting is DEATH YE: PLACE OF DEATH 28b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b. TIME 1b.	The underlying the un	UNCERTAL TO S Pasidence URY AT RK7 YES 2 NO and place, and due eath occurred at the	8 Oth 28d. DE 28t. LOC	24a. WAS AN / PERFORI 1 YES 2	AUTOPSY MED? AO AO AO AO AO AO AO AO AO A	24b. RED RED Coupe(s)	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO outs Number,

* Wante, Francis

3. TIME OF DEATH

Baltimore City

Approximate Interval Between Onset and Death

Folays

Johns Hophins

hours

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

30. NAME AND ADDRESS OF PERS

NAVIN SIN

31. DATE FILED (Month, Day, Year)
MAY 2 4 1995

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A REGISTRARY CONTURE

600 N. Wolfest

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Patrick

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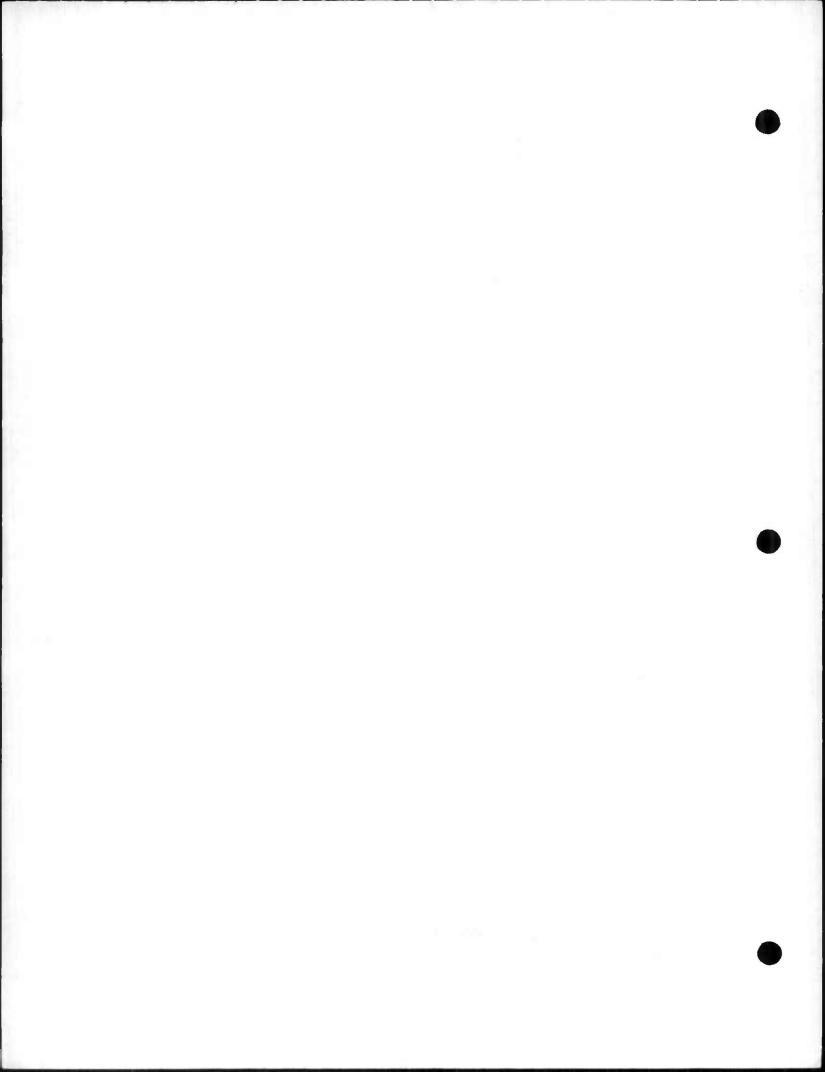
		Patric	.K	o' Bri	en	\				- 1		7.199	YEAR	11.17
		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE	(In yrs. les	t birthday)	IF UNDER 1 YE	AR IF UNDER	1 24 HRS. 7.	DATE OF BIRTH		S. BIRTH	PLACE (State or Foreign
D		215-16-424	2	1 M 2 □ F	73	3	YRS.	ONTHS DA	YS HOURS	MIN. M	(Month, Day, Year)	1922	Mar	yland
shoul	~	9s. FACILITY NAME (If not is	natitution, give s	treet and number)				96. CITY, TOV	WN OR LOCATI	ON OF DEATH	1	9c. COU	NTY OF DE	EATH
. 2, 3	DIRECTOR	THE JOHN	S HOPE	CINS HOSE	ITA	L		BALT	IMORE	CITY		Ва	alti	more Cit
iges 1	REC	10e. STATE	10b. COUNTY	1			10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY
nit. P.		MD	Anne	Arunde.	1		Har	wood						1 XYES 2 NO
physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	100. STREET AND NUMBER 4648 Muddy	Cree	k Road					2077				ZEN OF W	HAT COUNTRY?
cian. Frans	JNE	11. MARITAL STATUS	CICC	12. WAS DECEDEN	T EVER	IN U.S. ARI	MED	12 WAS			ORIGIN? (Specify Ye			- American Indian,
	BY	1 Never Married 2 2 3 Widowed 4 Dive		FORCES? 1	YES	25 N	Ö	If yes		n, Maxican, P	vario Rican, atc.)	8 OF ING-	Black, Specify	, While, etc.
aften ise as	윤	15. DEC (Specify onl	EDENT'S EDU	CATION completed)		16a. DE	CEDENT'S U	SUAL OCCUP	ATION	207	16b. KIND OF BU	SINESS/IND	USTRY	
the hospital or attending detached for use as the once.	COMPLETED	Elementary/Secondary (I		College (1-4 or 5	+)	1		raine	most of workin	•	Hors	ses		
3 & G	ш	17. FATHER'S NAME (Flist, M Patrick Fr	ancis	O'Brie	en				18. MOTH	theri	(First, Middle, Malder ne Cole	Sumame) Eman		
be retained be 5 should a notified	TO B	190. INFORMANT'S NAME (1		19t 4 6	MAILING A	ooness (Sin	cree	or Rural Route k Roa	o Number, City or Too	vn, Stata, Zip Wood	, MD	20776
age 6 may be director, page er must be		20a. METHOD OF DISPOSIT 1	on 3 🗆 Reme	oval from State	Cer	netery, crei	natory or other	DISPOSITION or place) mato:		5	DATE 200. LC	cation -		,
funeral funeral		21. SIGNATURE OF FUNERA	L SERVICE LIC	ZNSEE	2	nti	1			ss of Facility Fun	eral H	ome,	P.A	MD 21401
ted within 24 hours after of completely filled in by the ial, cremation, or removal.		23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	esit fellure.	Liet Dnly Dne cau	ise Dn e	ach line.	UENCE OF):	t enter the						Approximate Interval Betwee Onset and Deat 2 how
th certificate be execuending physician and I Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS	diete ING Iry	DUE TO	(OR AS)	A CONSEC	UENCE OF):	.lure arte		hise	ase			7 day
w requires that the dear been signed by the att pt. of Health and Merrta 3 shows any Injury,	MEDICAL C	PART II. Other signification	r.ten	49	deeth t	out not re	eaulting in	the underl	ying couse g	given in Par	1 1 TES	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
3 0 5 0		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE C	OF DEAT	TH YES	□ NO	□ UNC	ERTAIN [1 YES 2 D-116
V: The lancate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			OF DEATH	(Check only o						
SICIAN: The certificate ! h the State d, or Item	YSI	1 VES 2 NO		1. Inpatient 2		patient 3		OTHER: ☐ Nursing i	tome 5 ☐ Ra	sidence 8 🗆	Other (Specify)			
DING PHYSI After this c death with	ВУ РН		Pending Investigation	28e. DATE OF (Month, D			28b. TIME (RY .	INJURY AT WORK?		d. DESCRIBE HOW	INJURY OCC	URED	
TTENDI TOR: A after de 28 is	ETED		Could not be determined	28e. PLACE O building,	F INJURY atc. (Spe	f — Al hor	ne, larm, stre	et, lectory, o	office	281	I. LOCATION (Street City or Town, Stete)	and Number	or Rural Ro	oute Number,
PITAL OR A ERAL DIREC IN 72 hours	COMPLE			CIAN: To the best of R: On the bests of as										and menner as stated.
FUNI Withi		29b. SIGNATURE AND TITLE								NSE NUMBER				
TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 ho	O BE	NMS	EX.	WD							5725199	4	IAY	(Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

2. DATE OF DEATH MONTH

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	10 IHE FUNEMAL UHECTOR: After this certificate has been signed by the afterloing physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.
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Item # 1 Film # G 723 5-24-95 N.A. Per funeral Home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
REGISTRAR CERTIFICATE OF DEATH REG. NO.	
1. DECEDENT'S HAME (First, Middle AVA WILLIAM C. PRICE	3. TIME OF DEATH 12:02 P M
Willie C. Price MAY 22, 1 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH	
226 76 7644 TE M 2 DE MONTHS DAYS HOURS MIN. (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)
/ ·	20 VIRGINIA
	c. COUNTY OF DEATH
THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY	N/A
LU 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d, IHSIDE CITY
THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND ANNE ARUNDEL BROOKLYN PARK	LIMITS?
DROOMEN TAKK	1 YES 2 NO
10e. STREET AND HUMBER 200 12TH AVENUE 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or N FORCES? 172 YES 2 HO 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or N If yes, specify Cuban, Marican, Puerto Bloan, etc.)	
2 12. WAS DECEMBENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC OBIGINAL (Specific Vac or N	U.S.A.
I I I I I I I I I I I I I I I I I I I	No— 14. RACE — American Indian, Black, White, etc.
3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:	Specify: WHITE
15. DECEDENT'S EDUCATION 180. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINES	
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)	
	TRANSPORTATION
2	
16. MOTHER'S NAME (First, Middle, Last)	
JAMES PRICE RHODE ADAMS	telle. Zin Code)
JAMES PRICE RHODE ADAMS 19a. IHFORMANT'S NAME (Type/Print) 19b. MAILIHO ADDRESS (Street and Number or Rural Route Number, City or Town, Sta	
PAMES PRICE RHODE ADAMS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Sta 200 12TH AVENUE—BROOKLYN PA	ARK, MD. 21225
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Hopkins Hospital, Department of Survey

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

Kaufmann, mD

David Ka 31. DATE FILED (Month, Day,

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MD John Hopk

32. REGISTRAR'S SIGHATURED

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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24 hours	y filled in	ntion, or re
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	DIRECTOR: After this certificate has been signed by the attending physician and completely	hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremat
HE HOSPITAL	HE FUNERAL	ed within 72 I

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH	TH
		ALONZO CLAY PRICE MAY 21 1995 06:30	
pinous		212-48-5482 1 MM 2 of 48 YRS. MONTHS DAYS HOURS MIN. MARCH 20, 194, Country) 5.C.	preign
1. 2. 3	стов	96. CITY, TOWN OR LOCATION OF DEATH THE UNION MEMORIAL HOSPITAL BALTIMORE CITY Sc. COUNTY OF DEATH RESIDENCE OF DECEDENT 98. CITY, TOWN OR LOCATION OF DEATH SC. COUNTY OF DEATH A	
permit. Pages 1	DIREC	10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10c. CITY TOWN OR LOCATION 11x HISTORIC CITY TOWN OR LOCATION 11x YES 2	
is.	FUNERAL	100. STREET AND NUMBER 641 Gutman Ave 101. ZIP CODE 2/2/8 109. CITIZEN OF WHAT COUNTRY? 1.5. A.	
215-0020 attending physician. se as the burlal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify 20ban, Mexican, Puerto Rican, stc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— lif yes, specify 20ban, Mexican, Puerto Rican, stc.) 14. RACE — American India Black, Whita, stc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— lif yes, specify Yes or No— lif yes, specify Yes or No— lif yes, specify: Speci	an,
r attending use as the		15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	K
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2 2 2 E		17. EATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Malden Surname) 10. LOUIS 11. DO LE	
i, MARY be retained by ge 5 should by	TO B	1992. INFORMANT'S NAME (Type/Print) Price 1992-MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 104 Price	205
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20s METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	d
BALTIMORE after death. Page 6 may by the funeral director, pa moval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY 24. NAME AND ADDRESS OF FACILITY	
		23. PART I. Enter the diseases, or compilcations that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approxim	-1-
rely filled Is mation, or		interval B Onset and disease or condition resulting in death) BRAIN SWELLING AND SEIZURES DUE TO (OR AS A CONSEQUENCE OF): HYPER TENSIVE ARTERIO SCUENTIC CARDIO VASCUAR DISEASE EN ACCURATION OF THE PROPERTY OF THE PROP	etween
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OX e be es sician a orior to	CATIO	if any, leading to immediate cause. Enter UNDERLYING	-0
P.O. Entification of other	CERTIFICATION	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST	
S e d Pe		PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FI	PONION
O # B # E	MEDICAL	HISTORY OF A. (1, D. S. PERFORMED? 1 DYES 2 NO COMPLETION OF COMPLETION	10
S of s		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	NO
一年 皇皇 5	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)	
OF PHYSIC this cer with th	у РНУ	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 VES 2 NO	
ISIC TTENDI TOR: A after d after d	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office Dullding, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)	
₹ ₹ £ ₹	COMPLETED	29a. CERTIFIER (Check only one) 29a. The Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	
TO THE HOSPITAL TO THE FUNERAL be filed within 72 I	BE CO	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as at 29b. SIGNITURE AND TITLE OS CENTIFIER 29d. DATE SIGNED (Month, Day, Year)	Inted.
TO TO TO TO TO TO TO TO TO TO TO TO TO T	TO E	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs, Print)	
3		CHARLES C. BROWN, 40. 201 EAST UNIVERSITY MARKWAY BALTO, HA -21218	
		MAY 2 4 1995 Julia 3 ALEGUTAR SCOTULE	

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	t. DECEDENT'S NAME (First	Micielle Last)								2 DATE	OF DEATH		_	3. TIME OF DEATN
•	MONTH DAY YEAR											12:25p M		
	4. SOCIAL SECURITY NUMBER 5. SEX			6. AGE (In y	rs. last birthday)	IF UNDE	R 1 YEAR	IF UNDER	7 24 HRS.	7 DATE	OF BURTH		IPLACE (State or Foreign	
1	051-22-7857 15x M 2 □ F			66	YRS.	MONTHS	NTHS DAYS HOURS MIN.		Marc	n 1,19	29	Count	ew York	
į	9a. FACILITY NAME (If not in	nstitution, give s	treet and number)			96. CIT	Y, TOWN	OR LOCATI	ON OF D				INTY OF D	
e B	Franklin	Square	Hospita	1		Ro	sed	ale				Baltimore		
ן ק	RESIDENCE OF DEC	10b. COUNT												
DIRECTOR	MD		altimore B				nty town on Location altimore					10d. INSION		
FUNERAL	100. STREET AND NUMBER 7918 Belr			101. ZIP CODE 21236					10g. CITIZEN OF WHAT COUNTRY?					
5	11. MARITAL STATUS		12. WAS DECEDEN			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yai If yes, specify Cuban, Maxican, Puarto Rican, atc.)					or No. 14. RACE — American Indian,			
BY	1 Never Married 2 X 3 Widowed 4 Divo		FORCES? 1					S 2 X NO			Rican, atc.)	Black, White, etc. Specify: White		
		EDENT'S EDU		18	a. DECEDENT'S					16b.	. KIND OF BUS	INESS/IN		
₩	Elementary/Secondary (0	y highest grade 0-12)	College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done use retired.)	during n	nost of workin	ng					
릴	12		2	St	neet me	etal	Mec	hanic		C	onstru	ctio	n	
COMPL	17. FATHER'S NAME (First, M	liddle, Last)						18. MOTI	NER'S NA	ME (First, I	Middle, Malden	Sumame)		
ш	Anthony B	. Past	ernak					S	ophi	ie (U	nknown)		
0 8	19a. INFORMANT'S NAME (1) Joseph Pas	Type/Print) ternia	k Jr		7944 I	a AODRES	s (Street	Road	Bal	Route Numi	re, Md	. Star 2	36	
	20a. METHOD OF DISPOSIT			_										
	1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 🗔 Rem	ovel from State	20b. PL cemetar	ACE AND DATE ry, crematory or one n Mour	of DISPO	ema	tory		5/25			.more	, Maryland
- 1	21. SIGNATURE OF FUNERA	L SERVINE LIC	ENSER 11	11	en-Mour	22.	. NAME /	AND ADDRE	SS OF FA	CILITY T	he Dip	pel	Fune	ral Home Inc
	1 John	Y	John	10		71	10	Belai	r Ro					land 21206
	23. PARTY Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart/tailure.	List of it one cau	on each	IIIne.	VI)		ing, suc	- Care	nec or respii	ratory ar	reat,	Approximata Interval Batween Onaet and Daeth
CERTIFICATION	Sequentielly list conditions, It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.													
ERITE	that Initiated events resulting in death) LAST d.													
- 11	PART II. Other significe	ent condition	a contributing to	death but	not reaulting	In the u	nderlyl	ng ceuse g	given in	Part I.	24a. WAS AN		24b	. WERE AUTOPSY FINDINGS
DICAL					7							COMPLETION		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	1 TYES 20 NO									OF DEATH?				
2	1 Tes 2 No													
3	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)													
	EXAMINER?		HOSPITAL:	ER/Outpetle	int 3 DOA	OTHE 4 No		me 5 Re	ealdence	6 Othe	r (Spacify)			
PHYSICIAN:	27. MANNER OF DEATH	Pending	28s. DATE OF	TE OF INJURY 28b. TIME OF INJURY AT 28d. DESCRIBE NOW INJURY OCCURED WORK?										
9	The Natural 5 Pending Investigation 2 Accident Space of Could not be 28s. PLACE OF INJURY — At home, farm, atrast, factory, office 28s. PLACE OF INJURY — At home, farm, atrast, factory,									Poute Number,				
	4 Nomicide	detarmined	bullaing,	etc. (Specify)						City	or Yown, State)			
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	296. SIGNATURE AND TITLE			The state of the s		, ni my	Opinion,	-	ENSE NUI		ent piaca, and			(Month, Day, Year)
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	30. NAME AND ADDRESS OF	PERSON WH	OST/OL	SE OF DEATH	(ITEM 27) (Typ	Print)	To	RAR	4 4	tred	14-	[/M	Ma Iti	4 2PUS3
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

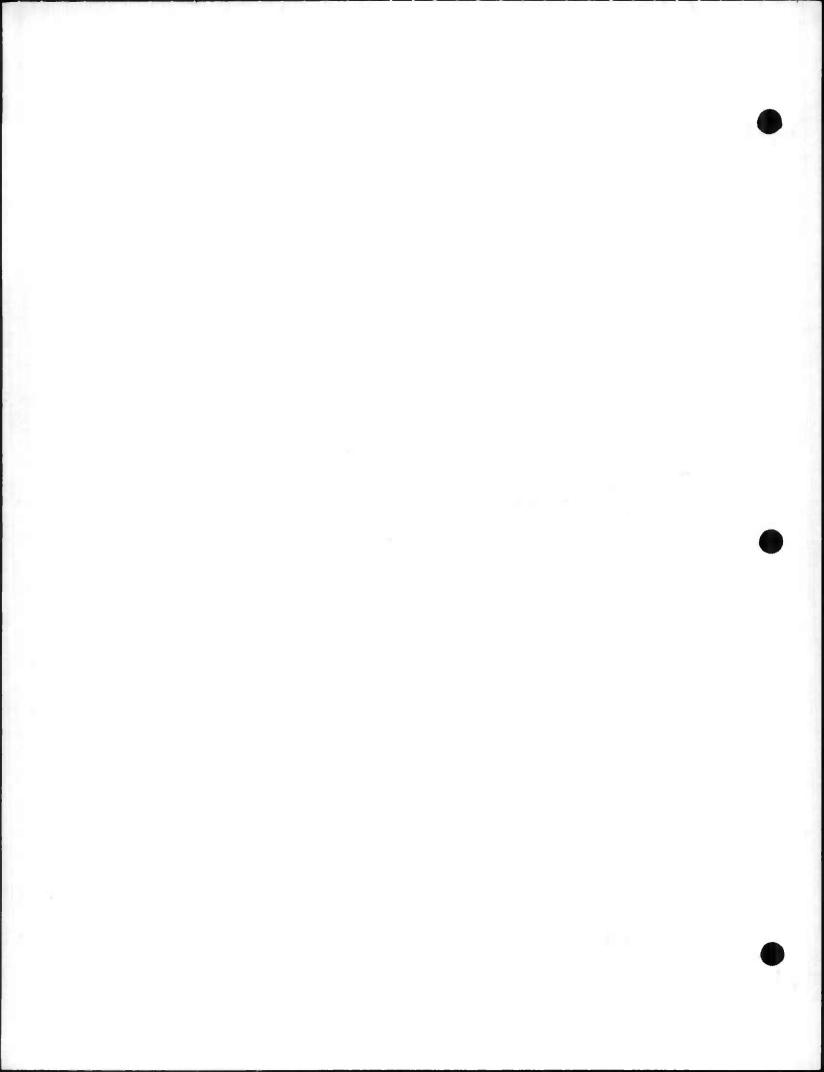
	1 - STATE REGISTRAR	STATE OF MARYL	ND / OEPART CERTIFIC			MENTAL HYGIEN	_							
	1. DECEDENT'S NAME (First, Middle, Last)		POEHLI			2. DATE OF DEATN		3. TIME OF DEATN						
	LILLIAN EL		May 17 1995 9:15 A											
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yber)		BIRTNPLACE (State or Foreign Country)						
	212-36-3433 10 M 2 10 F // YRS. Sep						23, 1917 Maryland							
œ	Meridian - Frank		OR LOCATION OF D	PEATN	9c. COUNTY									
DIRECTOR	RESIDENCE OF DECEDENT	-INS VV00045		Kossv			Dalit	imore						
RE	10e. STATE 10b. COUNTY		TOWN OR LOCA			10d. INSIDE CITY LIMITS?								
0	Md		G	arden			1 VES 2 NO							
FUNERAL	10e. STREET AND NUMBER		10	21206		10g. CITIZEN OF WHAT COUNTRY?								
NE	4516 Valley View Ave 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. AB						USA							
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Mexic	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, atc.						
84	3 Wildowed 4 Divorced	IF 1ES, GIVE WAN ON DA	163	1 1 1 1 1 1 2 3	2 NO Specif	ny:	1	Specify: NHITE						
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U	irk done during me	ON set of working	16b. KIND OF BUS								
E	Elementary/Secondary (0-12)	College (1-4 or 5 +)	me. Do NOT use	retired.)		Coovia	0000	e STORE						
M P	17. FATHER'S NAME (First, Middle, Last)		Monac	er				2 STORE						
	Charles Harr	201				AME (First, Middle, Maiden								
BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	DDRESS (Street	Bern	Route Number, City or Town	Wer To Co	da)							
5	Charles A. POEH	ER			Place	Baito.M								
	20a. METHOD OF DISPOSITION 1 Burlel 2 X Cremetton 3 Remo		PLACEANDDATEO	DISPOSITION (N		DATE 20c. LO		or Town, State						
	4 Donation & Other (Specify)	- Gr	een Mour		terr	5/22/15 Bal	to Ma							
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			S CHAP		EMOR	NES						
	Walest (1)	Liones		880	O Harfo			W. 21234						
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused	the death. Do no	t anter tha mo	de of dying, suc	ch as cardiac or reapi	retory arrest	Approximate Interval Between						
	IMMEDIATE CAUSE (Final	Oi	,					Onset and Death						
	disease or condition a. Pulmonary hypertension													
_	OUE TO (OR AS A CONSEQUENCE OFF.													
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
E	cause. Enter UNDERLYING													
E	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)											
H	resulting in death) LAST													
SAL	PART II. Other significant conditions	contributing to death be	it not resulting in	the underlyin	g cause given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS						
호	Chy	me otshuch	re lung	desens	-	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE							
핅	Me	infanct.	m		,,,,,,	OF DEATH?								
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PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (C/	heck only one)								
IYS	1 TYES 2 JANO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpe	tient 3 DOA	Mursing Hon		8 Other (Specify)								
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WC	RK?	28d. DEŞCRIBE HOW II	NJURY OCCUR	ED						
84	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	- At home, term, str		rES 2 NO	28f LOCATION (Street s	and Number or E	hural Bruda Mumbar						
<u> </u>	3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, term, street, factory, office City or Town, State)													
2 1	29a, CERTIFIER													
LETE	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my knowle	doe death occurred	CERTIFTIEN (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. Description of the data and place, and dua to the cause(a) and menner as stated. Description of the data and place, and dua to the cause(a) and menner as stated.										
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E COMPLETED	(Check only	On the basis of axamination				time, data and place, an	d dua to the ca							
8	(Check only one) 2 MEDICAL EXAMINER	On the basis of axamination	and/or investigation,		eath occured at the	time, data and place, an	d dua to the ca	use(a) and menner as stated. SNED (Month (Day, Year)						
	(Check only 1 DECENTIFYING PHYSIC ONe) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	and/or investigation, Phys. TN (ITEM 27) (Type, F	STEEN	29c. LICENSE NU	o time, data and place, an	29d. DATE SIG	GNED (Month foey, Year)						
8	(Check only 1 DENTIFYING PHYSIC ONe) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIED The first of the control of the certified of t	COMPLETED CAUSE OF DEA	TN (ITEM 27) (Type, Frankl	STEEN	29c. LICENSE NU	time, data and place, an	29d. DATE SIG	GNED (Month foey, Year)						

r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a lower lifer death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compliant mad in by the funeral director, page 5 should be detached for us	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bursa, cression, or remond.
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	1 - STATE REGISTRAR	STATE OF MARY	CE	ERTIFIC	CATE	OF	DEAT	TH	MENTAL	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)									F DEATH			3. TIME OF DEATH	
	Myrtle E. Patterson									MAY 20 1995			920 p	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. liest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIR (Month, Day) (Month, Day) (Month, Day)									F BIRTH	0.	BIRTHP Country)	LACE (State or Foreign	
	218-01-1484 1 M 2 KX F 89 YRS. MONTHS						HOURS	mere.		EB. 7, 1906 VIRGINIA				
~	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF													
ECTOR	LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE											E GEORGE		
EC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											1	lod. INSIDE CITY	
E I	MARYLAND HO		LAUREL									LIMITS?		
AL.	10e. STREET AND NUMBER 10g. CITIZEN OF													
8	9381 WHISKEY BOTTOM R	OAD					207	23				US	A	
P. P.	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. AR	MED	13. W	S DECE	NDENT O	F HISPAN	IIC ORIGIN?	(Specify Yar	s or No- 14	RACE -	- American Indian,	
BY	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 YE	DATES	Ю			cify Cube 2 XXNO		n, Puerto Ri	can, atc.)			White, etc.	
					1								WITH TE	
ETED	15. DECEDENT'S EDUC (Specify only highest grade		(Gi	CEDENT'S US five kind of wor Do NOT use :	rk done du			g	16b.	KIND OF BU	SINESS/INDUS	TRY		
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	, ma.	HOMEMA							N/E			
COMPL	17. FATHER'S NAME (First, Middle, Last)	V		HUMEMA	KEK		10 MOTE	ED'C NA	ME (Elect 14	ddle, Maiden	OME			
Ö	JAMES MARTIN SHERMAN								CE MILI		Surname)			
0	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING A	DDRESS (Street an					n, State, Zip Co	vde)		
임	PATRICIA R. HEISHMAN			5734 UN								1797		
ľ	20a. METHOD OF DISPOSITION	1							DATE	_			. State	
	1 Buriel 2 Cremation 3 Removal from State Commencer Comm													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE													
- 1	7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707													
_	23. PART I. Enser the diseases, or complications that course that death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
,	Interval Between Conset and Death Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAMES (Phone or Chicago C													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. UNWOWN THUM TWOWN CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
- 11	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 24s was an airmost													
₹ S												WAILABLE PRIOR TO		
EDIC/							-	-	-	1 YE\$ 2	NO	0	OMPLETION OF CAUSE F DEATH?	
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										☐ YES 2 Ø NO			
AN	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE		E OF DEATH			UNC	EKIAII	<u>ч </u>			L		
SICI	EXAMINER?	HOSPITAL:		C	THER:		Test:		5000	0.00				
PHY	27. MANNER OF DEATH	25a. DATE OF INJUR		28b. TIME (_		aldencs	6 Other		N.IURY OCCUR	ED		
	1 Natural 5 Pending	onding (Month, Day, Year) INJURY WORK?												
D BY	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY At home, ferm, street, factory, office 28f, LOCATION (Street and Murrher or Rural Ru								Rural Rou	ite Number,			
	4 Homicide determined	building, atc. (S)	лесту)						City or	Town, State)				
	29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner as attend													
	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. One) 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
	(Check only								time, date a			ause(s) s	nd manner as stated.	
COMPLET	(Check only	R: On the basis of examinat				ilon, des	th occur	ed at the			d due to the c			
BE COMPLETE	(Check only one) 2 MEDICAL EXAMINER	R: On the basis of examinat				ilon, des		ed at the			d due to the c		nd manner as stated.	
E COMPLET	(Check only one) 2 MEDICAL EXAMINER	R: On the pasie of examiner	tion end/or to	A 27) (Type, Pr	In my opin	ilon, des	29c. LICE	NSE NUN	IBER	nd place, an	d due to the c	SNED (A	forth, Day, Year)	



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FOR 1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIFIC	ATE O	F DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH
		Mildred C.	Raap				May 21	/995	10.45 AM
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BURTH		HTHPLACE (State or Foreign
		219-12-6231	1 🗆 M 2x🗗 F	70 YRS.	ONTHS DAYS	HOURS MIN,	(Month, Day, Year)	0	ountry)
should		Se. FACILITY NAME (If not institution, give a	treet and number)	//	h CITY TOW	N OR LOCATION OF DE		925 / Bc. COUNTY (lanyland
ان اند	Œ	208 Gaitner P		'			SAIT!		
. 2	16	RESIDENCE OF DECEDENT	Lace		<u> 46</u>	ingdon		Ha	infond
	DIRECTOR	10a, STATE 10b, COUNT	r	10c. CITY, 1	OWN OR LOC	CATION			10d. INSIDE CITY
Pages	1 5	Md. Ba	ltimore	P	arkv	: //0			LIMITS?
permit.		10e. STREET AND NUMBER	ccemoke		- T	10t. ZIP CODE			1 TES 2 NO
	&		1						OF WHAT COUNTRY?
020 physician. burlal-transit	FUNERAL	3420 Upton R				2/234			S.A.
215-0020 attending physician. se as the burlal-tra	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS D	ECENDENT OF HISPAN specify Cuban, Maxica	IIC ORIGIN? (Specify Yes	or No — 14, F	IACE — American Indian, Back, White, atc.
0 2 2	B	3€ Widowed 4 □ Divorced	IF YES, GIVE WAR OR D			ES 2 NO Specify			maniku.
215-0020 attending physic ise as the burlal-									White
	9	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of work	done during .	TION most of working	16b. KIND OF BUS	SINESS/INDUSTR	Y
M m E		Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use n	etired.)		1		
AND The hospit detached	₹	11th	N/A	Super	VILO	7	Vital	Stati	atica
AND the hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden		
# & & Z	ш	George C. G.	unzelman. S	<i>n</i> .		1:11:	an E. Pr.	22441	
MARYLAND retained by the hospit 5 should be detached notified at once.	8	George C. G.	The state of the s	19b. MAILING AD	DRESS (Street	t and Number or Rural I	Route Number, City or Tow	n. State. Zip Code)
	유	Mrs. Linda D. (Cullon	the second second second			Abingdon		,
ay be		20a, METHOD OF DISPOSITION		PLACE AND DATE OF	CCILEI	Name of			
To a second	1	1 General 2 Cremation 3 Ram	oval from State cen	netery, cremetory or other	nlace)		1	CATION — City of	
Page 6 m al director,		4 Donation 6 Other (Specify)		edar Hil	(Cen	retery	5/24 B	alto.,	Md.
- a -		21. SHIMATUIL OF FUNERAL SERVICE LIC	ENSEE		22. NAME	AND ADDRESS OF FA		1 11	
death. death. tunera		My D. J	my			ttley I'IL.	ller run	eral H	ome Md. 21234
		23. PART (Enter the diseases, pro	complications that cause	the death Do not	1/5/	/ Harto	rd Rd. Be	alto.	
hours after ad in by the or remove		shock, or heart feilure.	List only one ceuse on e	sch line.	differ the fi	lode of dying, suci	a a ceruisc or respi	ratory arrest,	Approximate interval Between
filled no.		IMMEDIATE CAUSE (Final disease or condition	W /~	10/	111.	/			Onset and Death
thely math		resulting in death)	DUE TO (OR AS	0/2 /	VIYO	210 MG	2		
d with			DUE TO (OR AS	CONSEQUENCE OF):					
od co	Z		b						
OX 68 e be execut sician and c rior to burit traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF):					
or the perior prior	3	cause. Enter UNDERLYING CAUSE (Disease or injury	c.						
d ph	區	that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):					
Fyding P.	토	resulting In desth) LAST	d.						
	S		-						
KDS, at the dea by the att and Menta y Injury,	A	PART II. Other significant condition	a contributing to deeth b	ut not resulting in t	he underly	ng ceuse given in	Pert i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
T 8 2 8 >	EDICAL	Hypertensi	ON CO	1017			1 YES 2		COMPLETION OF CAUSE
S 50 00							_		OF DEATH?
w require been sign. of He	Σ	DID TOBACCO USE CONTI	DIRLITE TO CALISE O	E DE ATH VEC		UNCERTAIN			1 TYES 2 NO
- B 5 5 K		25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (1 1		
N: The ficate h State	<u></u>	EXAMINER?	HOSPITAL:	0	THER:	e)			
SICIAN: The Certificate the State	XS	1 UYES 2 NO	1 Inpetient 2 ER/Outp			me 5/KRasidence	6 Other (Specify)		
OR ATTENDING PHYSICIAN: The OR ATTENDING PHYSICIAN: The OIRECTOR: After this certificate hours after death with the State Clem 28 is marked, or item	PHYSICI	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 28c. II	NJURY AT YORK?	26d. DESCRIBE HOW II	NJURY OCCURED	
NG PHYS fler this ceath with marked	BY	Netural 5 Pending Investigation			- C	YES 2 NO			
NDING H. After r death		3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	- At home, ferm, street	et, factory, of	lice	28f. LOCATION (Street a	and Number or Ru	ral Route Number,
OR ATTEN OR ATTEN DIRECTOR: Nours after Itom 28 Is	ш	4 Homicide determined	ounding, sec. (c)oc	,			City or Town, State)		
OR AI DIREC Hours	"	29a, CERTIFIER	CIANI, Ye do be a set of the	on samurates.					
A A Z	A P		CIAN: To the best of my know						
TO THE HOSPITAL. TO THE FUNERAL De filed within 72 IMPORTANT: II	COMPLET	4 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigation, i	n my opinion.	death occured at the	time, date and place, an	d due to the ceu	se(a) and manner as stated.
THE H	W	29b. SIGNATURE AND TITLE OF CERTIFIES	, /	/		29c. LICENSE NUM	BER	29d. DATE SIG	(Month, Quy, Year)
	8	5	1			10/60	16	1 5/	23/05
	유	30. NAME AND AODRESS OF PERSON WH	COMPLETED CAUSE OF DE	ATH OTEM 27/7/104. Pri	re)	0000		1-	-//
1/1		08/0 /30	0014	Pal					
. 0		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	_				
			4 1 14 1	A					
		MAY 2 4 1995 /	32 REGISTRAR'S SIGN	fall					

YEAR

9c. COUNTY OF DEATH

3. TIME OF DEATH

4:00a

8. BIRTHPLACE (State or Foreign

Anne Arundel

10g, CITIZEN OF WHAT COUNTRY?

Specify:

USA

Washington, DC

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 XES 2 NO

White

21035

21401

Approximate

24b. WERE AUTOPSY FINDINGS

AMAILABLE PRIOR TO

1 TYES 2 NO

29d. DATE SIGNED (Month, Day, Year)

COMPLETION OF CAUSE

Interval Between

Qneet and Death

2. DATE OF DEATH MONTH

May

22,1995

STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

harles

4 1995

31. DATE FILEO (Month, Day, Year)

Fred Mack Roberts

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The state of the s
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7. DATE OF BIRTH
(Month, Day, Year)
OCT. 14, 1936 1 XM 2 - F 58 577-48-2681 YRS. 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 4441 Co balt Drive Pages 1, 2, 3 Harwood RESIDENCE OF DECEDENT 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION MD Anne Arundel Harwood permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 4441 Co balt Drive 20776 burial-transit the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Never Married 2 Married FORCES? 1 YES 2 NO B 1 TYES 2 NO Specify: n by the funeral director, page 5 should be detached for use as the removal. 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) П Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Sales Candles 12 Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname Mack Roberts Phyllis Stoffel notified at Page 6 may be retained by BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
715 Petersburg Road, Davidsonville, MD 2 Martin Dresser 90 20a: METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Buriel 2 Cremation 3 Removal from State Donation 5 Other (Specify) _Hi Cemetery 5/ Suitland, MD Cedar examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF Hardesty FACILITY Funeral Home, P.A. nomos Ridgely Ave. Annapolis, MD 12 medical 23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arreet, completely filled in by ehock, or heart fallure. Liet only one cause onleach line. 6 **IMMEDIATE CAUSE (Final** the diseese or condition cule myocard resulting in death) event. DUE TO (OR AS A CONSE burial, many traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate prior cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in deeth) LAST 6 Mental Injury. the PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL by and any Signed Health 1 TES 2 NO shows : Deen 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\overline{\mathbb{D}}^{\text{t}}\) UNCERTAIN \(\square\) PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) Item State certificate EXAMINER? HOSPITAL: OTHER 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. OESCRIBE HOW INJURY OCCURED marked. with Natural M 1 YES 2 NO BY Investigation death 2 Accident After 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be DIRECTOR: after 28 4 Homicide hours Item 80 29a, CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. THE FUNERAL I filed within 72 h PORTANT: If II TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the couse(s) and manner as stated. 296 SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER BE mzar 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

> nzer 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

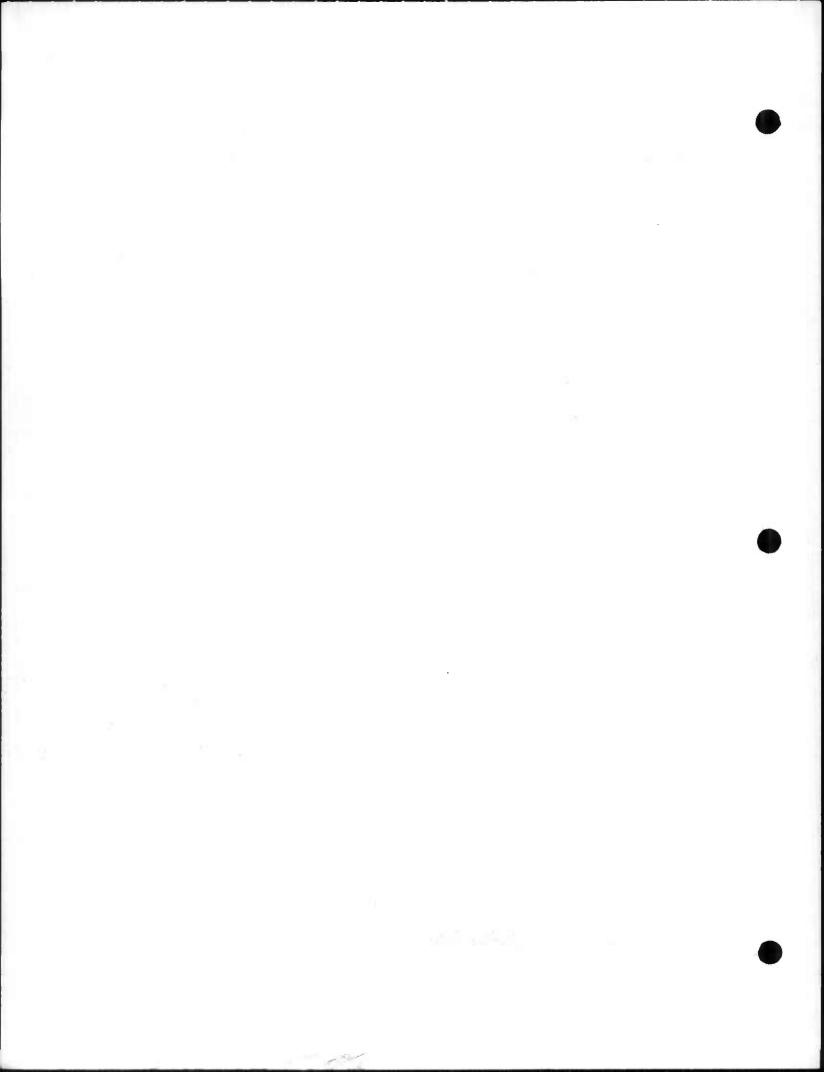
DAYS

IF UNDER 24 HRS

HOURS

6. AGE (In yrs. last birthday)

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurial-transf nermit Panes 1.2.3 ehround
be filed within 72 hours after death with the State Dept, of Health and Memai Hygiene prior to burlal, cremation, or removal.
IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ohn P. Kuddy 3:21 20 9.5 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 6/16/28 1 M 2 🗆 F DAYS HOURS 517-32-2873 Scotland 66 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University of Maryland Hospital Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore City 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2531 St. Paul St. 21202 U.S.A. 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, DIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. It yes, specify Cuban, Mexican, Puerlo Rican, etc.)

t \(\sum \text{YES 2 NO} \) Specify: 1 Never Married 2 Married ВУ White 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Unk. Unk. Social Worker Govt. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Stephen Ruddy Celina Padden BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 14812 Begonias La. Canyon Country, Ca. 91351 David Ruddy 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Greenmount Cemetery 5/24 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
B. Dabrowski & Son Funeral Home 10% 2818 E. Baltimore St. Baltimore, MD 21224 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition_ SLPSIZ W.F. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Pruchorin I WK. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: t YES 2 NO 1 Kinpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? INJURY 1 K Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER

(Check only

t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 🗌 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) BE rolost 37522 75 5 100

31. DATE FILED (Month, Day, Year)

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B. 1+. 5+

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

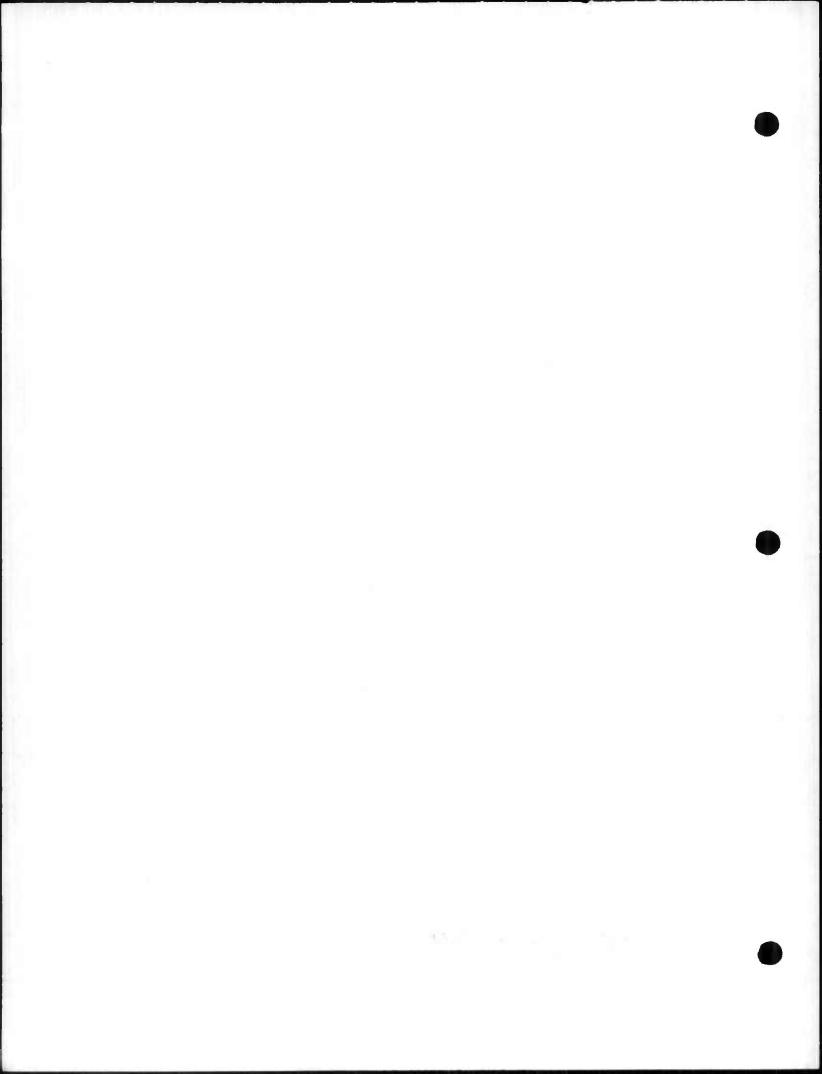
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	RUTH	Ellen	am) D T				2. DATE OF E	DAY		YEAR 3.	TIME OF DEATH	
	SURDI MAY 21, 1995								11:25 P				
	514-12-4517	1 🗆 M 2 💢 F	70	YRS.	MONTHS DA	_	OURS MIN.	Month, Day	(Manch	924 °	Country)	ACE (State or Foreign Kansas	
	9e. FACILITY NAME (If not institution, give alreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
DIRECTOR	THE JOHNS HOPKIN	S HOSPITA	L		BALT	IMOI	RE CITY				N/A		
3EC	10a. STATE 10b. COUNT	Y		10c. CITY	, TOWN OR LO	CATIO	N				10	d. INSIDE CITY	
	Maryland Ar	nne Arund	el			104 7	Pas	adena		44. 047.00		LIMITS?	
FUNERAL	208	Beach Ro		_		101. 2	211	22				States	
B≺	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 N	MED O	If yes	, specif	DENT OF HISPAN by Cuban, Mexican N NO Specify.	, Puarto Rican	ecify Yes o , etc.)	r No- 1	4. RACE — Black, W Specify:	American Indian, white, etc. White	
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	/Gh	m kind of w	USUAL OCCUP	PATION	of working	16b. KINI	D OF BUSIN	NESS/INDUS	STRY		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5 +) ///e.	omem	retired.)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, working			Ow	n Hor	ne	
SO	17. FATHER'S NAME (First, Middle, Last)	2.1.				1	8. MOTHER'S NAM	AE (First, Middle	, Maiden St	ımame)			
B	Eln 19a. INFORMANT'S NAME (Type/Print)	ner John						arah		tston			
2	John A. Surdi				each R		Number or Rural R Pasade			State, Zip C 1122	ode)		
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLACE A cametery, cren		han minant			DATE		ATION CH			
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE AA: 1+0	HILLT.	op Se		E AND	rp. 5/2	III CPPA				yland	\dashv
	milton !	Knight	n J Knig	ght J			larford	Leo		l. Ruck .more	,		
	23. PART I. Enter the diseases or cahock, or heart fellure.	complications that	caused the des	ith. Do no	ot enter the	mode	of dying, such	aa cerdiec	or reapira	tory arrea	it,	Approximata	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. Uros	ropsis									Interval Batwe Onset and Dea	
_	DUE TO (OF AS A CONSEQUENCE OF):												
01	Sequentially list conditions, ff any, leading to immediate DUS-TO (OR AS A DONSEQUENCE OF):									call			
CA	cause. Enter UNDERLYING CAUSE (Disease or Injury	- Psovi											
CERTIFICATION	thet initiated events resulting in death) LAST	d.	OR AS A CONSECU	JENCE OF)z								
Ö	PART II. Other significent condition	s contributing to	death but not re	aultina is	the under	ulaa a	nues alves la f	and I law	1400 044 44	-	T		
MEDICAL	00.1D	opituitens		enibe		- 4	ander given in i		WAS AN AL	ED?	AM	RE AUTOPSY FINDING AILABLE PRIOR TO EMPLETION OF CAUSE	- I
E I	1//			J	9-7/	Con U	/	_ ' -	YES 2	NO.	OF	DEATH?	-
	DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DEAT	H YES	S NO	9	UNCERTAIN				"	_ 123 24_ 110	
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		OTHER:	ine)					_		コ
KSI	1 YES 2 NO	1 Inpatient 2	-	DOA	4 - Nursing I		5 - Rasidence 8	Other (Spe	cify)				
BY Pt	1 Natural 5 Pending	28a. DATE OF I (Month, Da		28b. TIME INJU	IRY	WORK:		28d. DESCRIB	E HOW INJ	URY OCCUI	RED		
03	3 Suicide 6 Could not be determined	28a. PLACE OF building, o	INJURY — At hom vtc. (Specify)	io, farm, at	reet, factory, o	office		281. LOCATION City or Tow		1 Number or	Rural Route	Number,	٦
	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of r	my knowledge des	th occurre	d at the time	deta and	deless deless d		55. 6 sec.	0.00			\dashv
COMPLET	(Check only one) 2 MEDICAL EXAMINE											d manner as stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	MA				29	C. LICENSE NUMI	BER	12	9d. DATE S	IGNED (M	onth, Day, Year)	\exists
ဥ	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM	27) (Type, I	Print)		1-0144	-	,	3/	11/9	1	\dashv
	31. DATE FILED (Month, Day, Year)	Johns 1	Hopkis 1	tospit	4 600	N	Broaden	y Balt	chort	MD.	212	287	
ı	MAY 2 4 1995	32 REGISTRAF	Karlell				/						



BALTIMORE, MARYLAND 21215-0020	24 hours after death, Page 6 may be retained by the hospital or attending physician,	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE, I	ours after death. Page 6 may be	filled in by the funeral director, page
	24 11	fille

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF H	EALTH AND DEATH	MENTAL HYGIENE				
	1. DECEDENT'S NAME (First, Middle, List)	Charles Be				2. DATE OF DEATH DAY	995	3. TIME OF OEATH 12:05 A M		
	4. SOCIAL SECURITY NUMBER 5	i. SEX 6. AGE (In		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign		
	272 07 3310	× M 2 □ F 85	YRS.	NTHS DAYS	HOURS MIN.	Nov. 2,190	9 Ma	vryland		
~	9a. FACILITY NAME (If not institution, give stree		96	CITY, TOWN O	R LOCATION OF DI		9c. COUNTY OF			
DIRECTOR	Franklin Square Ho	spital		Rossu	ille		Ва	<i>ltimore</i>		
38	10a. STATE 10b. COUNTY	** **	10c. CITY, TO	OWN OR LOCATI				10d. INSIDE CITY LIMITS?		
	Maryland 100. STREET AND NUMBER	N/A				more City		1XX YES 2 □ NO		
FUNERAL				101.	ZIP CODE			WHAT COUNTRY?		
¥	2910 Harview Avenu	2. WAS DECEDENT EVER IN	LS. ARMED	13 WAS DECE	212	34 NC ORIGIN? (Specify Yes o		States E - American Indian.		
	1 Never Married 2 Married	FORCES? 1 YES	2)(NO	If yea, spe	cify Cuban, Maxica 2 NO Specifi	n, Puerto Rican, etc.)	Black	ck, White, etc.		
BY	3 🔀 Widowed 4 🗌 Divorced				-2,110 0,1001	<u></u>	Sp.	White		
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade cor	TION (Tipleted)	6a. DECEDENT'S USU (Give kind of work	done during mos	N t of working	16b. KIND OF BUSH	NESS/INDUSTRY			
ا ۲		College (1-4 or 5+)	life. Do NOT use re				,			
N N	8 Years 17. FATHER'S NAME (First, Middle, Last)		Canay	Maker	40 1407115010 114	ME (First, Middle, Maiden Si				
	William Starkey			1	Emma					
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street an		SIII Route Number, City or Town,	State Zin Code)			
임	Mrs. Janice Schaa	ike				altimore, M		7		
	20e METHOD OF DISPOSITION 1 D Burial 2 Cremation 3 Remova	20b. P	LACEANDOATEGED	SPOSITION /Nan	ne of	DATE 20c LOCA	TION - City or T	inum State		
	4 Donation 5 Other (Specify)	Ba	utimore	Cemeter	Ly 5/24/	95 Bal	timore.	Maruland		
-	21. SIGNATURE OF FUNERAL SERVICE LICEN	900		22. NAME ANI	D ADDRESS OF FA	uck, Inc.				
	Myren 7	· your		5305	Hankand	Road Balt	imaka	MD 21214		
	23. PARTY Enter the diseases, or com shock, or heart failure. Lis	oplications that caused t	he death. Do not	enter the mod	le of dying, suc	h sa cardiac or reapira	itory arrest,	Approximate		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)			- Ca	rdiov	ascula	disea	interval Between Onset and Death		
	a	DUE TO (OR AS A C						1933		
ERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
S	CAUSE (Disease or Injury									
	that initiated events	OUE TO (OR AS A C	ONSEQUENCE OF):							
E I	resulting in death) LAST									
C	PART II. Other aignificant conditions of	ontributing to death but	not resulting in ti	na underlying	cause given in	Part 1. 24s. WAS AN AI	UTOPSY 24	b. WERE AUTOPSY FINDINGS		
2	Prevmon					PERFORM 1 TYES 2	A .	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
							luc	OF DEATH?		
ż	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	1 2	0.721			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	Q6PtTAL:	PLACE OF DEATH							
XS.	1 VES 1X NO	Inpatiant 2 ER/Outpati		HER: Nursing Home	5 - Residence	5 Other (Specify)				
표	27. MANNER OF DEATH 1/ Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	WOR	IK?	28d. DESCRIBE HOW INJ	URY OCCURED			
E I	2 Accident Investigation	00 BLASE OF HUMBY			ES 2 NO					
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, atc. (Specify,	At home, term, stree	t, tactory, offica		281. LOCATION (Street and City or Town, State)	d Number or Rural	Route Number,		
	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the hant of our beauties	-2				(=20==5)			
29s. CERTIFIER (Check only one) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axe region and in retigation, in my opinion, death occurred at the time, data and place, and due								s) and manner as stated		
	29b. SIGNATURE AND TITLE OF CERTIFIER	111	//							
BE	asses ordered the title of Sentiries	(//4	aula -		29ch UCENSE NUN	326	▶ 5-22	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DUAT	H (ITEM 27) (Type, Prin	1)	010	000		,,		
	406 Eastern Bl	V	more. M		วา พ	00m C1	м м т			
	31. DYE FIVED WOM 1995 July	Philippe Books	#	<u>uZ_I_Z_</u>	LI Na	ieem Gauha	ir, M.	-		
	MAI 4 = 1333 /									

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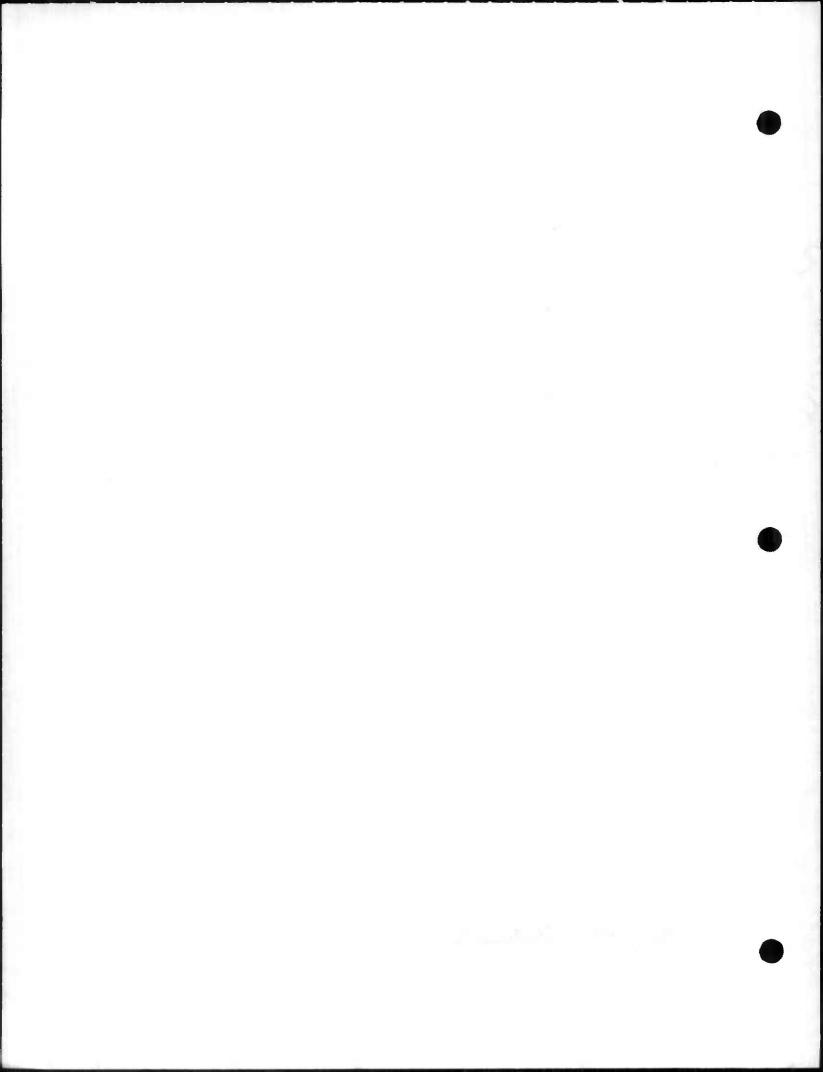
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Thelma :	F. SWar	2			May 2	3 1995	05:30 am	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a. BIR	THPLACE (State or Foreign	
	213-54-4085	1 DM 2 XF 4'	7 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 11-5-19		aryland	
	Se. FACILITY NAME (If not institution, give stre	et and number)		96. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF		
e o	Church Hospita	1		Baltin	nore Cit	tv	Balti	more City	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		1					-	
E				Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
	Maryland Balt	imore City	Ba.	ltimore				1 X YES 2 NO	
RA	703 S. Conklin	a Stroot		10	2.1.2.2.4			F WHAT COUNTRY?	
FUNERAL		12. WAS DECEDENT EVER IN I	110 40000	10 1110 000			USA		
	1 Never Married 2 N Merried	FORCES? 1 TYES	2 XNO	If yes, sp	ecify Cuban, Mexicar	HC ORIGIN? (Specify Years, Puerto Rican, etc.)		CE — American Indien, ack, White, etc.	
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 TYES	2 X NO Specify		Sp	White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or	TION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	HNESS/INDUSTRY		
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	vork done during me e retired.)	ist of working				
P P	10		Machin	e Oper	ator	Cleane	rs Han	ger Co.	
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Melden			
BE	Harry Schuman				Thelm	a Ramsey			
2	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural R	loute Number, City or Town	n, Stata, Zip Code)		
-	Thelma Schuman	1	703	S. Con	kling S	t. Balti	more,	Md 21224	
	20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 X Cremation 3 ☐ Remov		PLACE AND DATE (OF DISPOSITION (Nather place)	nme of	1	CATION — City or		
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	M	letro C	remato			1timor	e, Md	
	21. SIGNATURE OF FUNERAL SERVICE LICE	4366	0.4		DADDRESS OF FAC	aneral Ho	me of	Dundalk	
	Unthony C	olt Conn	elly	7110	S0110r	c Point	DA 21		
	23. PART I, Enter the diseases, or co shock, or heart vallure. Li	mplications that caused t	the death. Do n	ot enter the mo	de of dying, such	ss cardisc or respi	ratory arrest,	Approximate interval Between	
	IMMEDIATE CAUSE (Final								
	disease or condition resulting in death) s. Multipryan failure syndrome DUE TO (OR AS A CONSEDUENCE OF)								
- 1									
CERTIFICATION	Sequentially list conditions, b.	SEP DUE TO (OR AS A	41CG V	nia				14 Days	
E !	if sny, lesding to immediate cause. Enter UNDERLYING		Nemania.					100	
트	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	7):				12 Days	
TH	resulting in death) LAST	Live	C CIV	Thos	is				
	PART ii. Other significant conditions	contribution to death but	not requiting i	n the underlyin	anciale altitude for t	B. 3.1 2.1 10.2 11.2 1			
CAL		coholism	not resulting i	n me underlyin	g causs given in i	PERFOR	MED?	No. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
	_ CIMICATE TI	-0110113 M1				1 YES 2	XNO	OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	DUITE TO CAUSE OF	DEATH VE	C D NO M	LINICEDTAIN			1 YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT	S NO 2	UNCERTAIN	ч			
Sic	EXAMINER?	HOSPITAL:		OTHER:					
H	27. MANNER OF DEATH	28a. DATE OF INJURY	26b. TIMI	E OF 28c, INJ	e 5 Residence (26d. DESCRIBE HOW IN	JURY OCCURED		
	1 Natural 5 Pending	(Month, Day, Year)	INJ		RK? /ES 2 NO				
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY —	At home, farm, a	freet, factory, offic		26f. LOCATION (Street e	nd Number or Rura	I Route Number,	
COMPLETED	4 Homicide determined	building, etc. (Specify	7		- 1	City or Town, Stete)			
7	290. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowled	ige, death occurre	d at the time, date	end place, and due t	to the cause(e) and man	ner se stated.		
MO	one) 2 MEDICAL EXAMINER:	On the basis of examination s	end/or investigation	n, in my opinion, d	eath occured at the t	time, date end place, end	due to the cause	(e) and manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE SIGNE	ED (Month, Day, Year)	
38 C	Cleuball	e Lies	1		D388	82	1 5/2	3195	
5	36. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	(ITEM 27) (Type,	Print)			7/0		
	KHALID ALTIAL		hurch t	timo Ho	spital	100 N. Bree	Rusiy. P	althorne MD	
	MAY 2.4 1995 Jul	32 REGISTRAR'S SIGNATI	URE		1		7.		
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH THERESA MAY SECRET 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) NOV. 28, 1911 8. BIRTHPLACE (State or Foreign West Virginia 83 DAYS HOURS 235-12-8122 t M 2 X F YRS. beath. Page 6 may be retained by the hospital or attending physician.

Yuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION IDIA. INSIDE CITY LIMITS? Maryland Baltimore t X YES 2 NO 10e. STREET AND NUMBER FUNERAL tor. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4323 Seidel Avenue 21206 U.S.A. II MARITAL STATUS t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: t4. RACE - American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) ary (0-12) College (1-4 or 5+) 10th grade Riveter Manufacturing 17. FATHER'S NAME (First, Middle, Last) t8. MOTHER'S NAME (First, Middle, Maiden Surname) John Lopez Catherine Andu BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Flural Route Number, City or Town, State, Zip Code) 2 Mrs. Mary Loewenstein (dghtr) 1349 Quaker Church Road. Street. MD 21154 P 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Moreland Memorial Park 4 Donation 8 Other (Specify) 5/26 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Schimuner Funeral Homes, Inc. executed within 24 hours after death. 9705 Belair Rd., Baltimore, MD 21236 completely filled in by the rial, cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Batween **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition cute also cardral infarchen DUE TO (OR AS A CONSEQUENCE OF): 17 hrs resulting in daeth) traumatic event, Hygiene prior to burial, Coronara artery CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediata the attending physician 8 cause. Entar UNDERLYING CAUSE (Disease or injury certificate other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 the death Mental injury, PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE Health and that shows any Hypertensian t TYES 2 THO requires OF DEATH? wellitus t TYES 2 THO been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: Dept. MP 23 has 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The Item State HOSPITAL:
t V Inpetient 2 ER/Outpetient 3 DOA this certificate OTHER: OR ATTENDING PHYSICIAN: " t TYES 2 NO 4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) the marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with t t Natural 5 Pending м 1 YES 2 NO BY FUNERAL DIRECTOR: After I within 72 hours after death 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, stc. (Specify) -3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 28 determined Item 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 THE IMPORTANT: If IN 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(e) and menner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Takwaii Bo alea & M. Medical Resident May 22, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUSEPH BOATENG MD GOOD SAMARITAN HOSP. BALTIMOREA July 32 Maist Nave Constrail

Literature Control

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIA

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Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH монтн Мау 1995 YEAR Richard Crain Sponsler 18, 3:00a 4. SOCIAL SECURITY NUMBER BIRTHPLACE (State or Foreign Country) 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFITH 195-07-1182 DAYS 1 M 2 F 83 YRS. Dec.16,1911 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 305 Halsey Road Annapolis Anne Arundel RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Annapolis 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 305 Halsey Road 21401 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried ΒY 1 TES 2 NO Specify: Specify: 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Salesman 12 RetailSales 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) William A. Sponsler Ammiee Heighs BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Irma E.Sponsler 305 Halsey Road, Annapolis, MD 21401 20a. METHOD OF DISPOSITION
1 □ Burlet 2 □ Cremation 3 □ Re
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Metro Crematory 5/19 Baltimore, 21. SIGNATURE OF FUNERAL BER 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. alu 12 Ridgely Ave. Annapolis 21401 MD 23. PART i. Enter the diseasea, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart feilure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Finei** Onset and Death disease or condition resulting in deeth) PC OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying causa given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH VES TO NO TO LINCEDTAIN TO PHYSICIAN:

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27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year) 28b. TIME INJUR		28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOV	V INJURY OCCURED			
3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At home, building, etc. (Specify)	farm, atreet, fee	261. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
one) 2 MEDICAL EXAMINE	· ·				nanner se stated.			
296 SIGNATURE AND TITLE OF CERTIFIE			29c. LICENSE NU	IMBER	29d. DATE SIGNED-(Month, Day, Year)			
Bichach I	O COMPLETED CAUSE OF GEATH (ITEM 27	(Type, Print)	Murrau	A. A.	13 4. do (SB			
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow is a first death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICALI	E UF	DEAL	111		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													
	ELSIE MAY									1:40 P. M				
	4. SOCIAL SECURITY NUMBER	5. SED	K	6. AGE (In yr.	s. last birthday)		_	IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign
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5	MERIDIAN LOCH RAVEN RESIDENCE OF DECEDENT						TOV	ISON					BALT	IMORE
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B	FRANKLIN G.]	[DA]	ELLEN	HAMM	OND		
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	20e. METHOD OF DISPOSITION 1 M Buriel 2 □ Cremation 3	Removal Im	m State	20b. PLA	CE AND DATE	OF DISPOS	ITION (No	ma of		DATE	20c. LOC	CATION —	City or Tov	vn, State
	4 Donation 5 Other (Spec	cify) _	oune	WIS	EBURG	CEME	STER	Y		5/25	5/95 V	WHITE	HALL	, MD
- 1	21. SIGNATURE OF FUNERAL SEI	RVICE LICENBEE						D ADDRES						
- 1	1//									AL H				
\neg	39 PART I Enter the disease	sea, or complic	etions that	caused the	death. Do	not anter	the mo	LOCH de of dyl	RAV	EN B	VD.	TOWSC	N. N	D 21286
H	anock, or neart	feilure. List on	ly one caus	se on aach	line.		,	/	ng, saci	n ala care	iac or reapi	atory arri	Jac.	Intarval Batween
	IMMEDIATE CAUSE (Final disease or condition		0		-		1	1	-1	-	0			Onset and Death
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3	25. WAS CASE REFERRED TO ME	DICAL			LACE OF DEA					•				
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È∥	27, MANNER OF MEATH		a. DATE OF	INJURY	28b. TIN	\rightarrow	28c. INJ		eroence	-	CRIBE HOW IN	JURY OCC	URED	
	1 Natural 5 Pendi		(Month, Da	y, Year)	IN.	IÓRY M	1 🗆 1		ON				-	
Accident investigation M 1 YES 2 NO 3 Suicide S Could not be 28s. PLACE OF INJURY — All home, form, street, fectory, office 28st. LOCATION (Street and Number 1)							nd Number	or Bural Br	usta Alumbar					
	_ 0 _ 00000	d not be mined	building, e	etc. (Specify)			.,,				r Town, Stete)	TO THORNOUS S	or norm no	ote reamon,
91	29e, CERTIFIER			_			_						_	
<u>F</u>	(Check only	G PHYSICIAN: To												
COMPLET	2 MEDICAL I	EXAMINER: On the	o basis of ex	amination and	for investigation	n, in my o	pinion, d	eath occur	ed at the i	ilme, date	end plece, end	due to the	ceuse(e)	and manner ee stated.
BE	296. SIGNATURE AND TITLE OF C	CERTIFIER -		21 -				29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED/	Month, Day, Year)
ē.	100	price	or he		MI	D.		D	15	41.	7	•	57.	23/15
For	TO. NAME AND ADDRESS OF PEA	SON WHO COMPI	LETED CAUS	E OF DEATH (TEM 27) (Type		-,,	4 400	1.	/	2/ 0	01		1
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	31. DATE FILED (Month, Day, Year)	1 32	REGISTRAF	'S SIGNATUR	E									
	MAY 2 4 1995	yalra d	Thursday.	Mardall										
		/				-								DMMH 16 Day 1/00

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3. TIME OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2. DATE OF CEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

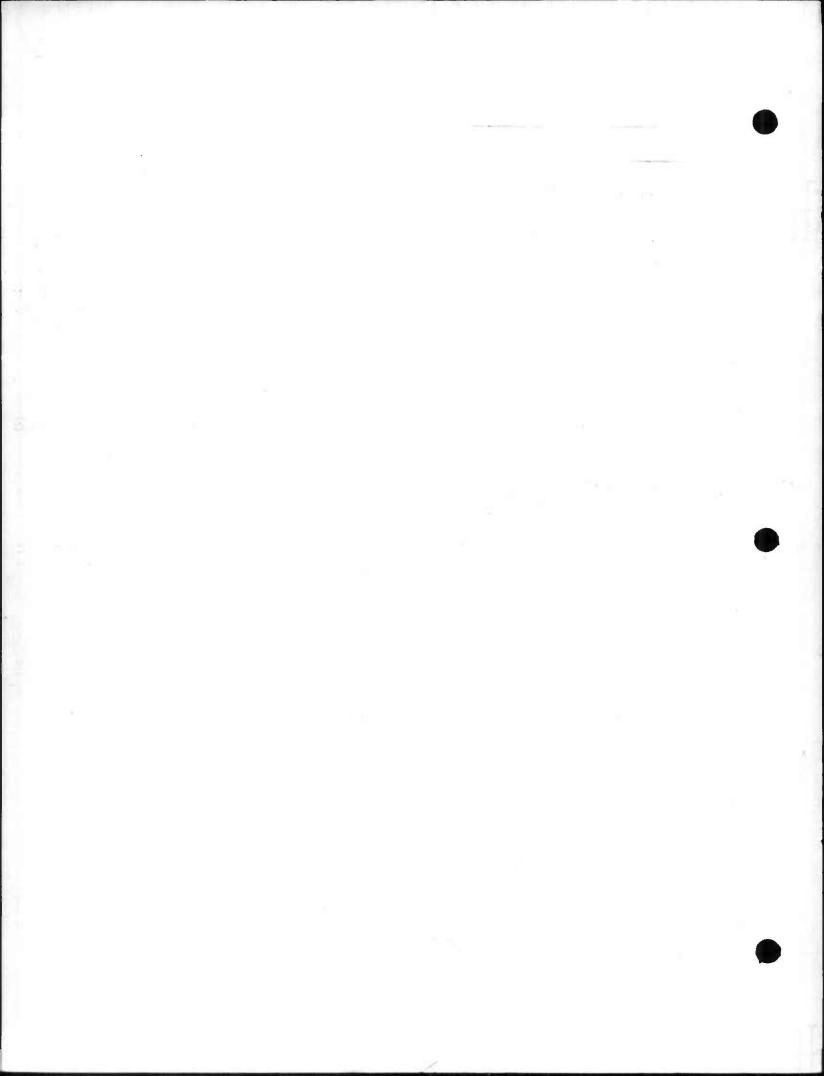
	72	4. social security number 216-43-0390	5. SEX 6. AGE	MARK ANDRE	COLEMAN FUNDER 1 YEAR MONTHS DAYS	JR . IF UNDER 24 HRS, HOURS MIN.	7. DATE OF	Day, Year)	S. BIRTHPLACE (State or Foreign Country)	м
permit. Pages 1, 2, 3 should	L DIRECTOR	98. FACILITY NAME (If not institution, give s STAGNES HOSPIT RESIDENCE OF DECEDENT				OR LOCATION OF DE			TY OF DEATH	
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215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	II yes, s	CENDENT OF HISPAI pocify Cuban, Maxica S 2 NO Specif	in, Puerto Ric	(Specify Yea or No — an, etc.)	14. RACE — American Indian, Black, White, atc. Specify: Black	
21 for u	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT us	work done during n se retired.)	TON nost of working	16b. K	IND OF BUSINESS/INDU		٦
YLAND 2 by the hospital be detached for at once.	COMPL	17. FATHER'S NAME (First, Middle, Lest)	0. 0.	700	٤			die, Meiden Sumeme)	1.	\dashv
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	1	21. SIGNATURE OF FUNERAL BEHVICE LA	lado			and adoress of Fa 1 Sandy Spr	ŀ	Fleck Funeral ad, Laurel, N	Home, Inc. Maryland 20707	
the fours mation, or ren		23. PART 1. Enter the disease, ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	ROSE	WATER	u	FAILLER	Y	c or reapiratory arre	Approximate interval Between Onset and Das	ath
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	SICIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE O		YES NO	O D			-
F VITAL SICIAN: The law certificate has h the State Dept d, or Item 23	YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 is inputient 2 in ER/Out		OTHER:	me 5 🗆 Rasidenca		Specify)		
이 돈 를 할 수	ву РНҮ	27. MANNER OF DEATH 1 Maturel 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	INJ	M 1 🗆	JURY AT ORK? YES 2 NO	28d. DESCI	RIBE HOW INJURY OCC	URED	
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is man	ETED	3 Suicida 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJUR building, etc. (Spe	Y — At home, term, secify)	streat, factory, off	lca		ION (Street and Number (Town, State)	or Rural Route Number,	
1 2 2 2 1	COMPLI	000)	ICIAN: To the best of my known in the best of examination						ed. e cause(a) and manner se stated.	
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3		30, NAME AND ADDRESS OF PERSON WHAT THE TOTAL TO	COSAGUO 32, REGISTRAR'S SIG	P. Ar	(05, N	W, 87	. HEN	3 My	PITAL	

32, REGISTRAR'S SIGNATURE

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Louise Schuster May 19, 1995 3:30 A 4 SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) 1 - M 2XX DAYS 212-05-1224 April 190d Balto, 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH Prince George Marinder Nursing Home Laurel 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Paltimore City Baltimore YES 2 NO 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4306 Newport Avenue 21211 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: 3 Wildowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntery/Secondary (0-12) College (1-4 or 5+) Telephone Operator C&P Telephone Company 8th 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lena Catter 17. FATHER'S NAME (First, Middle, Last) James Ray 19a. INFORMANT'S NAME (Type/Pr 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Marchesiello 13429 Rich Lynn Court Highland, Maryland 20777 20a. METHOD OF DISPOSITION

To Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Moreland Memorial Park 5/22 Parkville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home Balto, Md 3631 Falls Rd 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervei Between shock, or heert fellure. List only one cause on each line. **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO lance COMPLETION OF CAUSE 1 YES 2 000 OF DEATH? 1 YES 2 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗖 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Phursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF OEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Watural 5 Pending 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, term, atreet, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 8 Could not be 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEOICAL EXAMINER: On the beals of exami nation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE.SIGNED (Month, Day, Year) 247 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once
CIVISION OF VITAL RECORDS, F.O. BOX 68760 BALLIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once

		1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) Katherine Roxanne Thomas 2. DATE OF DEATH MONTH DAY YEAR	
		-HattleFine A Homas May 19 1995 7:01 A	M
-		TOTAL AND THE DAYS HOURS MIN. (Month, Day, Year) 30 Country)	٨
2, 3 should	_	9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH	7
1, 2, 3	DIRECTOR	2 ina Hospital of Baltimore Baltimore City Bothmore City	
Sages	REC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS2.	
permit. Pages 1,		100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?	
isi	FUNERAL	5818 Stuart Avenue 21215 United States	
physician. burial-transit		11. MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT DE-HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, 15. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 16. RACE — American Indian, 17. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 18. RACE — American Indian, 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OR HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OR HISPANIC ORIGIN? (Specify Yea or No— 19. Was DECENOENT OR HISPANIC	
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by the hose be detach		17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame)	
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 21 William James Tracey 6:29 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7 DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 11-24-1941 DAYS HOURS 215-40-1395 1 XM 2 | F Maryland YRS use as the burial-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll Co. Gen. Hospital Westminster Carroll RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 24 NO Maryland Carroll Millers FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? 4213 York Rd. #1 21107 U.S.A. attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 AYES 2 NO IF YES, GIVE WAR OR DATES 1963-1965 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 00 Married Specify White BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
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1 DABurial 2 Cormation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Pleasant Grove Cem. 5-25-195 4 Donation 6 Other (Specify) Upperco, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY after death. Ershardt Houth Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, filled in by Approximete shock, or heart failure. List only one cause on sech line. interval Batween 9 **IMMEDIATE CAUSE (Finel** Onset and Death the cremation. disease or condition_ Qn. completely resulting in death) traumatic event, DUE TO (OR minule burial, CERTIFICATION pure Sequentially list conditions, DUE TO (OR AS A CONSCOUENCE OF) 2 If any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 0 Mental 1 shows any injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO and and utolen signed the COMPLETION OF CAUSE 1 | YES 2 | 10 OF DEATH? 1 | YES 2 10 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES WNO UNCERTAIN PHYSICIAN: has be Dept. item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL: OTHER 1 YES 2 AO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ome 5 🗆 Residence 6 🗆 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c is marked, 1 Natural Pending 1 YES 2 NO BY After 2 Accident Investigation 26a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED DIRECTOR: hours after 28 4 Homicide item 29e. CERTIFIER

(Chart out 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER. 29c. LICENSE NUMBER 29d, DATE SIGNED /Mor BE th. Day. Yo D 23015 22 95 MND 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DINESH S. 217 WASHINGTON HGTS WESTMINSIL 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and heart of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

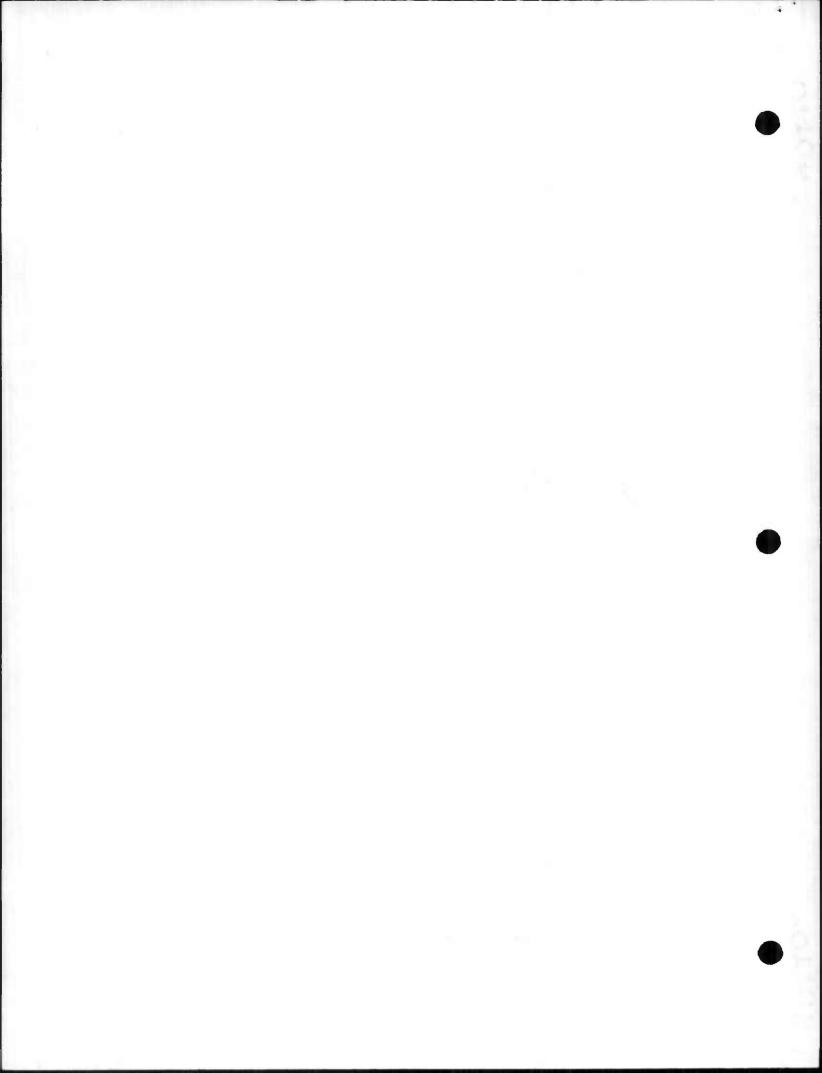
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) Donald F. Voelker 2. Date of Death MONTH DAY 1995 6:35 PM									
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE									
	212-18-9127 1 ∑ M 2 □ F	73 YRS.			(Month, Day, Year) ANUARY 10,19	922 MA	RYLAND			
œ	9a. FACILITY NAME (If not institution, give street and number) LAUREL REGIONAL HOSPITAL			LOCATION OF DEAT	Н	9c. COUNTY OF				
5	RESIDENCE OF DECEDENT		L.F	AUREL		PRINCE	GEORGE			
DIRECTOR	MARYLAND PRINCE GEORGE	10c. CITY,	TOWN OR LOCATIO	ON AUREL		10d. INSIDE CITY LIMITS? 1 YES 2 X NO				
3AL	10e. STREET AND NUMBER		10f.	ZIP CODE		F WHAT COUNTRY?				
FUNERAL	8501 SNOWDEN LOOP			0708		US	Α			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER FORCES? 1 YES, GIVE WAR OR 1944 - 1947	8 2 NO	NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black			ACE — American Indian, eck, White, etc.				
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	SUAL OCCUPATION k done during most	t of working	16b. KIND OF BUS	INESS/INDUSTRY	,			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	ELECTRONIC	retired.)		US COVE	ERNMENT				
Š	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME	(First, Middle, Maiden	Sumame)				
BE	EDWARD HERMAN VOELKER			BESSIE SMI	LSAL					
5	19a. INFORMANT'S NAME (Type/Print)				te Number, City or Town	, State, Zip Code)				
-	LIBBY VOELKER	8501 SN	OWDEN LOOF	P, LAUREL	, MARYLANI	D 20708				
		Db. PLACE AND DATE OF Printery, cremetory or other ALT I MORE - WAS				CATION - City or				
	4 Donation 5 Other (Specify) B	ALTIMURE-WAS		ADDRESS OF FACILI	_		RYLAND			
1	- Part Dock	6.	I		FLECK FU	NERAL HOM REL, MARY	E, INC. LAND 20707			
_	23. PART 1 Enter the diseases, or templications that cause	od the death. Do not			CONTRACTOR SECTION	COCCOR COLOR	Approximate			
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읦	Sequentially list conditions, if any, leading to immediate DUE TO [OR AS A CONSEQUENCE OF]:									
5	CAUSE (Disease or Injury	A CONSEQUENCE OF:								
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Ĭ	27. MANNER OF DEATH 28s. DATE OF INJURY	26b. TIME (F 26c. INJUI	5 Residence 6 RY AT 26	J Other (Specify) Id. DESCRIBE HOW IN	JURY OCCURED				
BY P	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		M 1 YE	K?						
COMPLETED	3 Suicide 8 Could not be determined 26s. PLACE OF INJUR	nd Number or Run	al Route Number,							
1 2	29e. CERTIFIER (Check only (Ch	wiedgs, daath occurred	at the time, date as	nd place, and due to t	the cause(s) and men	her as stated.				
No.	one) 2 MEDICAL EXAMINER: On the basis of examinati						e(a) and menner as stated.			
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	LUIS A. CASAS	m) 8		ERRY L	ANE LA	UREC M	4) 20707			
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32 REGISTRAR'S SIGNATURE HELLA D'EURISSE MANALELL

Page 6 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

n and completely filled in by the to burial, cremation, or removal.

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OR ATTENDING PHYSICIAN: The I DIRECTOR: After this certificate ha hours after death with the State De

BALTIMORE, MARYLAND 21215-0020

Item1,18,Film723,5/24/95,1t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH LOUISE WASHINGTON 995 AM MAY 9 1:12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign OCT. 28, 56 1938 225-52-8282 1 | M 2 | X | F HOURS YRS Virginia Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MERCY HOSPITAL E.R. BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY N/A Baltimore XXYES 2 NO FUNERAL 10a, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21202 26 S. Exeter Street Apt. 8D U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TES 2 NO Specify: Black Specify: BY 3 🔀 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Nursing Home 8th Laborer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eddie Jones Rochelle Thomas BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 S. Exeter Street Apt. 4J/Baltimore, MD 21202 2 Patsy Williams METHOD OF DISPOSITION

Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State ship 5-24 1 X Buriel 2 Cremetron 4 Donation 6 Other (Specify) "Mt". "Minnis "Cemetery Chesterfield. VA 22. NAME AND ADDRESS OF FACILITY
March Funeral Home East 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1101 E. North Avenue/Baltimore, MD 21202 Varen 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart feliure. List only one cause on each line. interval Retwe IMMEDIATE CAUSE (Final **Onset and Death** than a Claratic Cardiovascular Diseau oue to (or as a consequence of): disease or condition resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to deeth but not reaulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TYES XX NO 1 YES 2 NO INSPECTION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 | Inpetient | 3 | DOA 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY Natural 2 Accident 5 Pending 1 YES 2 NO BY 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide datermined 29e. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. *XXMEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) unte MAY 19,1995 ND O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

TO THE FUNERAL TO THE FUNERAL I BE filed within 72 h

FUNERAL D

Item19a,Film723,5/24/95,1t

DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Z4	The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ibe filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTA	L HYGIEN				
	DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATN			YEAR	3. TIME OF QEATN	
	RODNEY	BERNARD	BERNARD WASHINGTON				MAY 17			6:47	Ри
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In	EX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTY 8. BIRT						. BIRTNI	PLACE (State or F	Foreign
	219-80-3436	1XXM 2 □ F 34	YRS.	ONTHS DAYS	HOURS MIN.	JAi		1961		TIMORE,	MD :
œ	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN O	R LOCATION OF C	DEATN		9c. COUNT			
DIRECTOR	JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a										
REC	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION				ION					10d. INSIDE CIT	γ
	MARYLAND n/a			BALTIMORE				1 XXYES			NO
FUNERAL	1202 HOMEWOOD AVENUE							HAT COUNTRY?			
JNE	11. MARITAL STATUS	ILS ADMEO	21202				UNITED STATES				
	1) Never Married 2 Married FORCES? 1 YES 2 (1)			O If yes, specify Cuban, Maxican, Puerto Ri				can, etc.) Black, White, etc.			llen,
ВУ	3 Widowed 4 Divorced	The state of the s		I I TES	2 NO Speci	ıγ:			Specify	BLACK	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. OECEDENT'S U (Give kind of wo	rk done during mos	N at of working	16	b. KIND OF BU	SINESS/INDU	STRY		
J.	Elementary/Secondary (0-12)	College (1-4 or 5+)	LABORE	_	ITODIAL		DO	N/ = 0			
M	17. FATHER'S NAME (First, Middle, Last)	=	LABURE	K- JAN	ITORIAL		B00		CTOF	ξ Y	
	THOMAS WASHI	NGTON JR.				ELIA		len Surname)			
BE (19a. INFORMANT'S NAME (Type/Print)	ASHLINGTON	19b. MAILING A	DDRESS (Street or				CHOL SON			
2	ELSIE WAH W	\$	1202	MAILING ADDRESS (Street and Number or Rural Route Number, City of 202 HOMEWOOD AVENUE, BAL				TIMORE, MARYLAND 2120			21202
	20a. METHOD OF DISPOSITION 1 □ Buriel 2 □ Cremetion 3 □ Remo		LACE AND DATE OF			DAT		CATION - CI			21/20/2
	4 Donation 5 Other (Specify) MT. ZION CEMETERY 5-25 LANSDOWNE MARYLAND								D		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							1			
	MAN	(paex			C. MARCH					AVEN	JE.
	23. PART i. Enter the diseesea, or of ahock, or heert feliure.	templications that ceused that only one cause on eec	the death. Do no	t enter the mod	le of dying, aud	ch aa car	diac or respi	ratory arres	st,	Approxim	
	IMMEDIATE CAUSE (Final							Onset an			
	disease or condition mEGACOLON AND VOLVULUS										
_	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentielly liet conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):								+		
S	cause. Enter UNDERLYING CAUSE (Disease or injury										
	that initiated events resulting in death) LAST										
E I	d										
AL (WERE AUTOPSY F			
S	X						AVAILABLE PRIOR COMPLETION OF OF DEATH?				
ME							1 YES 2	NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
ICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	3. PLACE OF DEATH	(Check only one)							
HYS	1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify)										
	1 Netural 5 Pending (Month, Day, Year) INJURY			TY WOF				NJUHY OCCU	JRY OCCURED		
ЭВУ	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, tac				1 YES 2 NO			(Street and Number or Rural Route Number,			
E	4 Nomicide determined building, etc. (Specify)								1		
COMPLETED	29e. CERTIFIER (Check only (Ch										
MO	one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated.								stated.		
BE C	294 SHOMATURE AND TITLE OF CERTIFIER								SIGNED (ED (Month, Day, Year)	
TO B	Marie Welfrill									18,1995	
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)										
ļ	MARY BLUTP 1.16 LEU WW 111 Penn Street, Baltimore, Maryland 21201								201		
	31. DATE FILED (MONTH OF YOU'Z) 4 199532. REGISTIANS JANATURE CALLEL										

95-2851-005

Pages 1, 2, 3 should

permit.

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 that the death certificate be

HOSPITAL

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Varid

31. DATE FILED (Month, Day, Year)

2 41995

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

12. REGISTRAR'S SIGNATURE

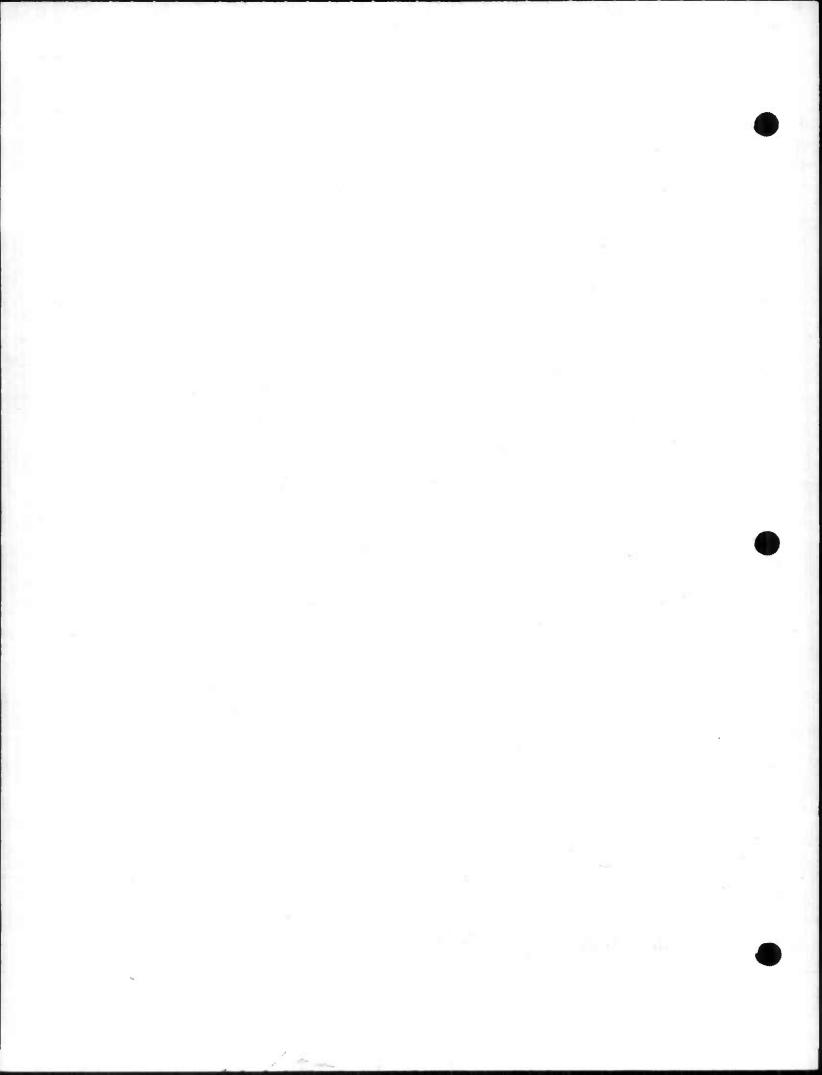
funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. and completely filled in by the oburial, cremation, or removal. prior to the attending physician I Mental Hygiene prior to n signed by the Health and N t. of F . OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has be hours after death with the State Dept.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 95 MAY OUIS 7:05 WILSON MILLIAM 16 AM. 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) B. BIRTHPLACE (State or Foreign 251-66-4414 1 M 2 F HOURS S.C. YRS March 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY arulano 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 21215 a 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, apecify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 11. MARITAL STATUS
1 Never Merried 2 Merried 14. RACE — American Indian, Black, White, atc. If yes, specify Cuba 1 YES 2 NO BY Specify: BLACK 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) dary (0-12) College (1-4 or 5+) 2th degu avade 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle notified at BE FORMANT'S NAME (Type 2 EGGU GOS. KMONT 5 Ave 9 20a, METHOD OF DISPOSITION

1 Spuriel 2 Cremation 3 Removal from State 20h: PLACE AND DATE OF DISPOSITION (Name of cometery_crematory on other place) 20c. LOCATION - City or OATE must 5/23 inry cremetory go other pla onation 5 Other (Specify) examiner 23. NAME AND ADDRESS OF FACILITY
MARCH FUNCER 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 21215 WASHU MILL 300 0. medicai 23. PART II. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory Approximats shock, or heart feliure. List only one cause on each line. Interval Batwe portensive atherosclarche Cardioviscular but to (or as a conseduence of): IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ resulting in death) traumatic event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEDUENCE OF)that initiated eventa resulting in death) LAST 9 PART II. Other aignificant conditions contributing to death but not reaulting in the underlying ceuse given in Pert I. PHYSICIAN: MEDICAL 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 24a. WAS AN AUTOPSY any 1 YES 2 NO YES 2 ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\overline{\ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK7 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 90 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE FUNERAL ID THE FUNERAL ID THE FUNERAL ID TO THE FUNERAL ID TO THE FUNERAL ID TO THE ID THE ID THE ID THE ID TO THE ID THE ID TO THE ID TO THE ID TO THE ID TO THE ID TO THE ID TO THE ID TO THE ID TO THE ID TO THE ID 2 X MEDICAL EXAMINER: On the besie of ex and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERUSIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) MAY 17,1995 O.C.M.E.

DHMH-16 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

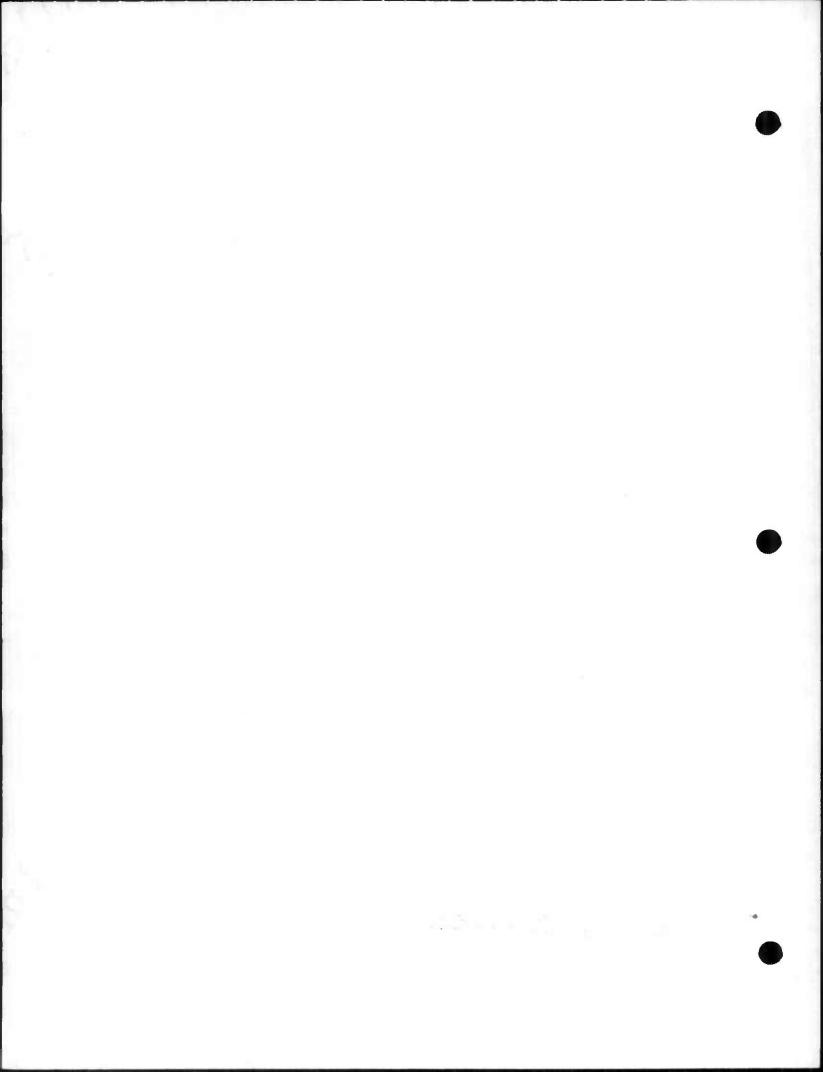


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withment hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. For the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
) THE HOSPITAL OR ATTENDING PHYS) THE FUNERAL DIRECTOR: After this if fled within 72 hours after death with	APORTANT: If item 28 is marked

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM								
	DECEDENT'S NAME (First, Middle, Lest) GRACE	rst)				REG. NO. 2. DATE OF OEATH MONTH DAY YEAR MAY 20.1995			3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	WILLIAMS 5. SEX 8. AGE (In yrs. last birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS.				MAY 2	7:30 a. M				
	216-12-9247	1 □ M 2 및 页	O YRS.	NTHS DAYS	IF UNDER 24 HRS. NOURS MIN.	DEC.	⁵ , 14	BALT	IMORE, MD		
20	THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY						n/a				
DIRECTOR		The Strip Tolling on Education					10				
	100. STREET AND NUMBER 101. ZIP CODE						1 XVES 2 NO				
FUNERAL	501 E. PRESTON STREET APT. 231 21202						UN	ITED	STATES		
ğ	1 Never Married 2 Married 3 Widowed 4XX Divorced	Never Married 2 Married FORCES? 1 YES X NO If yes, specify Cuban, Marker					an, Puerto Rican, etc.) Black, White,				
COMPLEIED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4 or 5+) 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of work life, Do NOT use retired.)				ON ost of working	16b, KIND OF BUSINESS/INDUSTRY					
	10 TH					CAN COMPANY					
ш	17. FATHER'S NAME (First, Middle, Lest) WILLIAM G. SAMPSON CLA				AME (First, Middle, Malden Surname)						
2	19a. INFORMANT'S NAME (Type/Print) EDWARD SAMPSO	EDITOR OF THE PROPERTY OF THE									
	20s. METHOD OF DISPOSITION 1 AD Burlid 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelox, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of camelox or other place)										
	VOSHELL MEMORIAL GARDENS 5-25 DUNDALK, MD 21. BIGNATUTE OF FUNERAL SERVICE LICENSEE WM. C. MARCH FH1101 E. NORTH AVENUE										
TISICIAN: MEDICAL CENTIFICATION	ahook, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition BILIARY SEPSIS 7							Approximate interval Batween Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
		nificant conditiona contributing to deeth but not resulting in the underlying cause given in Part I. TIA, CHRONIC RENAL INSUFFICIONCY					WAS AN AUTOPSY PERFORMED? YES 2 NO	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN						1 TYES 2 NO				
5	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)										
	1 YES 2 ANO 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Realdence 8 Other (Specify)										
	Natural 6 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF NORK? M 28c. INJURY AT WORK? 1 YES 2 NO				28d. DEŞCRIBE HOW INJURY OCCURED					
	3 Suicide 8 Could not be determined						281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				
	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
	286. SIMMATURE AND TITLE OF CERTIFIER										
2	M.D. M.D.										
	VARGHESE TOWER 110 JOHNSHOPKINS HOSPITAL										
	31. WAY 2-41995 July 10 100 100 100 100 100 100 100 100 100										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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-	Item17,Film723,5/24/95,1	t							9	5	15862	
	1 - FOR STATE REGISTRAR	STATE OF M			MENT OF			MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) MILDRED	M.	WA	157	(E)	2		2. DATE OF DEATH	22,	19ega	3. TIME OF DEATH	
		1 🗆 M 2 🖄 F	8. AGE (In yrs. les	YRS.	IF UNDER 1 YEAR	HOURS	MIN.		1914	Ma	APLACE (State or Foreign	
TOR	Church Hospital	eet and number)	Baltimore						9c. COU	N/A		
DIRECTOR	Maryland 10b. county	N/A			TOWN OR LO						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	356 Gusryan Stre					2122				U. S.	what country?	
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA		MED IO	If yes,	ECENDENT OF specify Cuban ES 2 1 NO	, Maxican	IC ORIGIN? (Specify Yes i, Puarto Rican, etc.)	or No—	or No— 14. RACE — American Indian, Black, White, etc. Specify,		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) 8th Grade	ATION ompleted) College (1-4 or 5+)	16a. DE (Gi life.	CEDENT'S U we kind of wo Do NOT use CLETI	SUAL OCCUPA rk done during retired.)	TION most of working	9	16b. KIND OF BUS		DUSTRY		
BE CO	17. FATHER'S NAME (First, Middle, Last)					wil	heme	RE (First, Middle, Malden LNIA Volle)	rt			
10	198. INFORMANT'S NAME (TyperPrint) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1149 Circle Drive, Baltimore, Maryland 21227											
	29a. METHOD OF DISPOSITION 1A Burlet 2 Cremation 3 Remov 4 Donation 5 Other (Specify)				DISPOSITION Proplace	l Gard	ens 5	126/95 Be	cation – l Ai	City or To	wn, Siete Uryland	
	21. SIGNATURE OF FUNEBAL SERVICE LICE	K			333	1 Breh	ms L	ieral Home ane, Balt	imore	2, Mc	l. 21213	
	23. PART Entar tha diseasea, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	only one caus	ART	- P.	AIL C	noda of dyir	ng, auch	aa cardiac or respi	ratory ar	rest,	Approximate interval Between Onset and Death MonTHs	
RTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF): DUE TO (DR AS A CONSEQUENCE OF):								YEANS	
PHYSICIAN: MEDICAL CEI	DIASETES MELLITUS DIASETES MELLITUS d. 24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 ▼ NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								AVAILABLE PRIOR TO COMPLETION OF CAUSE			
IAN: N	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAU			Ocheck only on		RTAIN				22 10	
		HOSPITAL: I Inpetient 2 I 28s. DATE OF IN (Month, Day,	JURY		OF 28c. I	NJURY AT VORK?		Other (Specify) 26d. DESCRIBE HOW IN	JURY OC	CURED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide delarmined	28a. PLACE OF building, at	INJURY — At hor	ne, ferm, str		YES 2		281. LOCATION (Street a City or Town, State)	nd Number	nd Number or Rural Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:										and manner as stated.	
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF DEBSON WAR	emí	~	0		29c. LICEN	ISE NUME			E SIGNED	(Month, Day, Year) 22, 1995	

MPLETED CAUSE OF DEATH (TERM A)

2. NA ZEM!

32. REGISTRAR'S SIGNATURE)

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

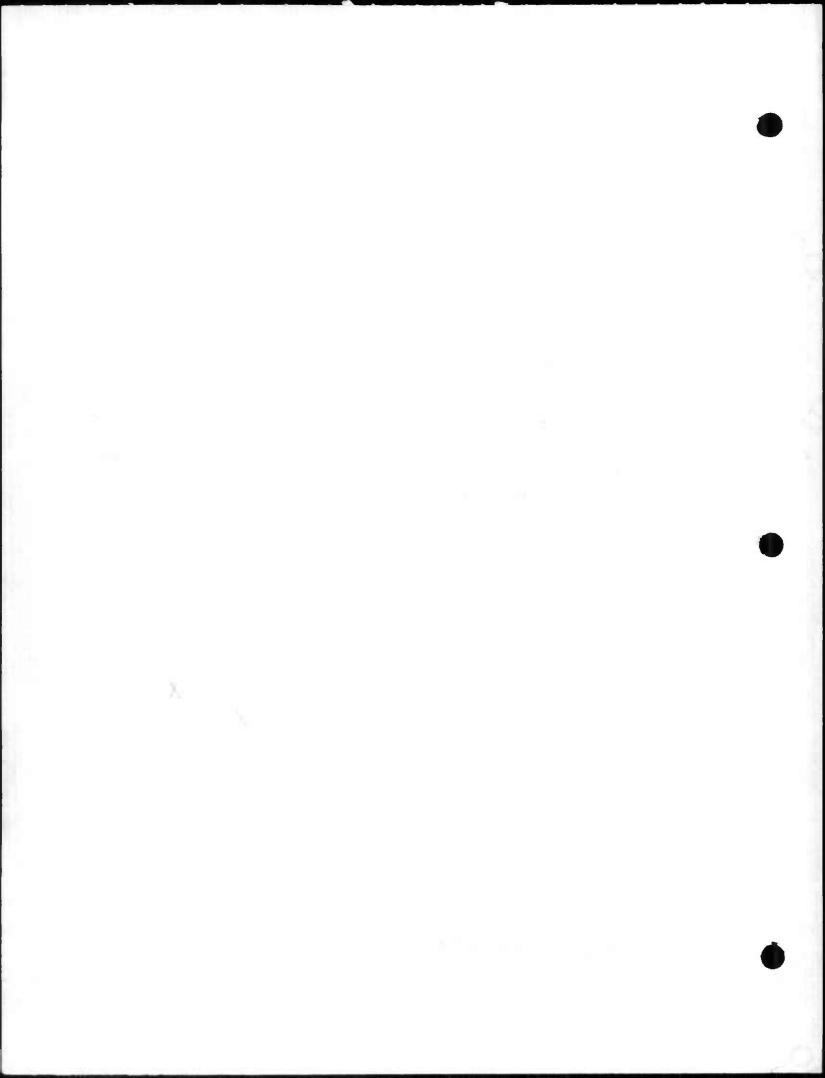
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FilmG, 723, item	#1. 4. 5	/30/95.cs	w. ner	f h		95	5863	
			AND / DEPAR	-	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	1	*			2. DATE OF DEATH		3. TIME OF DEATH	
	4. SOCIAL SECURITY, NUMBER 5. SI	house C	(In yrs. last birthday)	IF UNDER 1 YEAR	dhouse	5 2	0 9	5 2:45 A M	
	215-30-8214 IX	XM 2 □ F	62 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB. 26,1	933	BALTIMORE, MD	
DIRECTOR	9a. FACILITY NAME (If not institution, give street an BAYVIEW HOSPITAL RESIDENCE OF DECEMENT	nd number)		96. CITY, TOWN O	IMORE	CITY	4	n/a	
REC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	13.14			10d, INSIDE CITY VLIMITS?	
	MARYLAND 100. STREET AND NUMBER	n/a		BALTI				1 TYES 2 NO	
FUNERAL	327 W. 27 TH	STREET			109. ZIP CODE 109. CITIZEN OF WHAT COUNT UN ITED STAT				
BY	1 Never Married 2 XXMarried F S Widowed 4 Divorced	MAS DECEDENT EVER FORCES? 1 X YES FYES, GIVE WAR OR E	N U.S. ARMED 2 NO MATES	If yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 No Specify: 1. RACE — American Black, White, etc. Specify: LACI				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete and the comp		16a, DECEDENT'S (Give kind of v life. Do NOT us		ON st of working	186. KIND OF BU	RUCTIO		
OM	17. FATHER'S NAME (First, Middle, Last)	_	LADOI	VLIV	18. MOTHER'S NA	ME (First, Middle, Maider		N CO.	
BEC	CARLTON R. WOOL	DHOUSE			HELEI				
TO E	19a. INFORMANT'S NAME (Type/Print) JEANETTE NANCY WOODHOUSE/NORRIS 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3665 WABASH AVENUE, BALTIMORE, MD 2								
20a. METHOD OF DISPOSITION 1 Disposition 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemelory, crematory or other place) DATE 20c. LOCATION — City or Town, State									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		ARRISUN _		VA CEM		WINGS	MILLS, MD	
	> Inlast	TAC	/					RTH AVENUE	
	23. PART i. Enter the diseases, or complishock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	n:		h aa cardiac or reap	Iratory arres	t, Approximata Interval Between Onset and Death	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO (OR AS	OLL MY A CONSEQUENCE OF A CONSEQUENCE OF Y HMM): -					
CAL C	PART II. Other algnificant conditions con	tributing to death t	out not reaulting i	n tha undarlying	g causa given in	Part I. 24a. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
MEDICAL						1 YES	A CHO	OF DEATH?	
	DID TOBACCO USE CONTRIBU	TE TO CAUSE C	F DEATH YE	S NO C	UNCERTAIN	V D		1 D YES 20 NO	
PHYSICIAN:		SPITAL:	26. PLACE OF DEAT	OTHER:					
HYS		Expetient 2 ER/Out	28b. TIMI	OF 28c. INJ	URY AT	6 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCUE	RFD.	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	JRY WO	RK? 'ES 2 NO				
TED		28e. PLACE OF INJURY building, etc. (Spe	— At home, ferm, e	treet, factory, office		281. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,	
29a. CERTIFIER (Check only one) 29a. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.							ause(a) and manner as stated.		
w	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN			JGNED (Month, Day, Year)	
0 8	Faina Gidan	MO			45004	/	> 3	90/95	
	30. NAME AND ADDRESS OF PERSON WHO COM	MD.	4940 51	ASHLLA	Ave,	bAltomo	RO M	0 21224	
	MAY 2 4 1995	THE LEASE	HALL.						

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DIVISION	

		STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	SINIE OF MANTE		ICATE OF	DEATH	MENIAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (FISH, MIDDIE, LIST)	1/ 1/18	21 2 .	_ /		2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER		41701			May 21,	1995	3:25a M	
			.55.	(in yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	S. Bit Co	RTHPLACE (State or Foreign untry)	
Page 1		214-38-0548 9a. FACILITY NAME (If not institution, give a		6 YRS.			Jun.6,19		ryland	
3 should	СТОВ					OR LOCATION OF DE	EATH	9c. COUNTY OF		
~		Anne Arundel Medical Center Annapolis Anne Arundel								
Pages 1	ш	10s. STATE 10b. COUNT			Y, TOWN OR LOC				10d. INSIDE CITY	
23	DIR	MD Anne	ARundel	Anı	napolis	5			LIMITS? 1 YES 2 NO	
permit.	AL AL	10e. STREET AND NUMBER			1	Of. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	
is is	ERAL	705 Tyler Aven	ue			21403		USA	1	
DAVSician. burial-transit	FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No.— 14. R	ACE — American Indian,	
		1 Never Married 2 Married	FORCES? 1 YES			pecify Cuban, Mexica S 2 NO Specifi	n, Puerto Rican, atc.)		pecify: White	
attending physic se as the burial	ВУ	3 Widowed 4 Divorced				Z.			wille	
use :	TED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind of	USUAL OCCUPAT	TION nost of working	16b. KIND OF BU	SINESS/INDUSTRY	Υ	
d for u	LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Homemal	se retired.) Ker			wn Hom	ne	
the hospital detached to	COMPL	17. FATHER'S NAME (First, Middle, Last)								
by the be deti		Grover Clevelan	d Carrick				ME (First, Middle, Malden Caroline			
trained by should by tiffed a	H	19a. INFORMANT'S NAME (Type/Print)	d carrier							
retained 5 should notified	유		FORD	100. MAILING	ADDRESS (Street		Route Number, City or Tow	/	21412	
A SO L		20a, METHOD OF DISPOSITION		. PLACE AND DATE	11106		MNAPOLIS		31107	
age 6 mg director,		1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		Ticres			5/23 An	cation - city or inapoli	S. MD	
		21. SIGNATURE OF FUNERAL SERVICE LIC				UND ADDRESS OF FA				
		The Ad	Na late				neral Ho	ome, P.	Α.	
0 - 6	\vdash	Momes N9	+anaesu		12	Ridgely	Ave. Ann	apolis	MD 2140	
in the		23. PART i. Enter the diseeses, or a shock, or heert failure.	complications that coused List only one cause on e	d the death. Do i each line.	not enter the m	ode of dying, auc	h as cardiac or reapi	ratory arrest,	Approximate interval Between	
		IMMEDIATE CAUSE (Final disease or condition	D		_	,			Onset and Death	
within 24 ipletely fill cremation, rent, the		resulting in death)	a. Responses	IND JENY	1	22 chre				
B 6 8			DUE TO USER AS A	A CONSEQUENCE O	F):					
e be executed within sician and complete rior to burial, crema traumatic event,	ERTIFICATION	Sequentially list conditions,	b. DUE TO (OR AS (CONSEQUENCE O	50.	7 61	3			
ag cian B	Į Į	if any, leading to immediate cause. Enter UNDERLYING		OONSEODENCE O	۲).					
certificate ding physi hygiene pr	띮	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):					
	E	resulting in death) LAST	4							
at the death by the attent and Mental H	2									
at the by the and Me	MEDICAL	PART II. Other significent condition	s contributing to deeth b	out not reaulting	in the underlying	ng ceuse given in	Pert I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
8 3 5 G	ă						1 YES 2	NO	COMPLETION OF CAUSE OF DEATH?	
law requires as been sign lept, of Heali									1 YES 2 NO	
has be bept.	SICIAN:	DID TOBACCO USE CONTI					V X			
at at at	호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one OTHER:)				
CIAN ertific the S	ΥS	1 VES 2 NO	1 Inpetient 2 ER/Outp		4 - Nursing Ho	me 5 🗌 Residence	6 Other (Specify)			
도 물로 말	РНУ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	IURY W	JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCURED		
ting P	B	2 Accident Investigation	200 DI ACE OF WHITE			YES 2 NO				
L DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St Item 28 is marked, or it	8	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	— At nome, term, :	street, factory, offi	Ce .	28f. LOCATION (Street a City or Town, State)	ind Number or Run	al Route Number,	
DR AT DIRECT hours a	Щ	29a. CERTIFIER								
TAL D TAL D	₽ I	(Check only CERTIFYING PHYSI	CIAN: To the best of my know							
THE HOSPITAL THE FUNERAL IN 1664 WITHIN 72 H	COMPL		R: On the basis of examination	n and/or investigatio	on, in my opinion,	death occured at the	time, data and place, an	d due to the caus	e(a) and manner as stated.	
THE HOSPI THE FUNEF filed within PORTANT:	BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	IBER	29d. DATE SIGN	ED (Month, Day, Year)	
5 5 3 W	TO.	non				1776	141	1 5/2	2/95	
2	- 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print) //D	0.1/2	/	/		
)		AJUST NIVA	Road, Mr.	MADOLL	s, MD	X140				
4		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE "	/					
		MAY 2 4 1995 9	THE PURPLE	DELL						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	t, Middle, Last)	Domes	. ^	1.74 1	1:00					2. DATE	of DEATH	W Q 5	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUM	BER	Betty 5. SEX		WILL yrs. lest bi		IIS IF UNDER 1 Y	EAD	IF UNDER	94 (490	7.0475	OF BIRTH	95	0 01071	IPLACE (State or Foreign
	220-42-91		1 □ M 2 🔁 F	o. roz (m				AYS	HOURS	MIN.	05-	-06-4	5	Ma	ryland
_	Sa. FACILITY NAME (If not in	nstitution, give et	treet and number)				9b. CITY, TO	OWN C	R LOCATI	ON OF DE	HTA		9c. COU	NTY OF D	
DIRECTOR	2007 Belv		Avenue	<u> </u>			Ва	1t	imor	:e				N/A	
Ä	10e. STATE	10b. COUNTY	7		-	10c. CITY,	TOWN OR	LOCAT	ION						10d. INSIDE CITY LIMITS?
	MD.		N/A				Ва		imor						1 € YES 2 □ NO
FUNERAL	100. STREET AND NUMBER 2007 Belv		Avenue	2				101	212				10g. CIT	U.S	WHAT COUNTRY?
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARME	ED .	13. WA	S DEC	ENDENT C	F HISPAN	IIC ORIGIN	? (Specify Yes	or No-	14. RACE	E — American Indian.
BY	1 Never Married 2 3 Widowed 4 Dive		FORCES? 1 IF YES, GIVE V						ecify Cube 2 성급 NO			Rican, etc.)		Speci	k, White, atc.
3	18. DEC	CEDENT'S EDUC	CATION		18e. DECE	DENT'S U	SUAL OCCI	JPATIC	ON		16b.	KIND OF BUS	INESS/ING	DUSTRY	
	Elementary/Secondary (College (1-4 or 5	+)	life. Do	o NOT use	rk done duri retired.)	ng mo	st of world?	19					
COMPLETED	9th		0		C	ate	rer					Host	Mar	rio	tt
	17. FATHER'S NAME (First, M Jessie T		adway									Will			
O BE	19a. INFORMANT'S NAME (Type/Print)			19b, k	MAILING A	DDRESS (S	treet a				er, City or Town			
-	John W.		way		5	409	May	vi	ew A	lven	ue !	Balto	., N	ID.	21206
	20e, METHOD OF DISPOSIT 1	on 3 🗆 Remo	oval from State	20b. F	PLACE AND tary, crema	DDATE OF	DISPOSITION (ON (Na	me of	/	DATE	20c. LO	CATION -		1
	21. SIGNATURE OF FUNERA		ENSEE	- 0	edai	r Hl		_	D ADDRE						e, MD.
	► Nou	tha	Hector) (CESP	<i>1</i> 428								-	Monroe St. D. 21217
	23. PART i. Enter the d	lisesses, or c	complications the	t caused	the desti										Approximate
	iMMEDIATE CAUSE (Fit disease or condition resulting in death)		a. 120 A	Aic	F	til	uro								Onset and Death
2			DOE AS	PASA S	CONSEQUE	ENCE OF):	DI A	i	101	^					12 MO
CEHILICATION	Sequentially list condit if any, leading to imma cause. Enter UNDERLY	idlete iNG	DUE TO	(OR AS A C	CONSEQUE	ENCE OF):									
	CAUSE (Disease or injuthet initiated events		DUE TO	(OR AS A C	CONSEQUE	ENCE OF):									
5	resulting in death) LAS	" (d												
	PART II. Other algorifics	ent condition	a contributing to	deeth but	t not res	uiting in	the unde	riying	ceuse (given in	Part I.	24a, WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS
EDICAL											_	1 YES 2	,		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME															1 TES 2 NO
Š	DID TOBACCO U		RIBUTE TO CA					_	UNC	ERTAIN	1 🔲				
PHYSICIAN	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			- 1	(Check only		-/						
2	1 YES 2 NO		1 Inpatient 2 I			DOA 4	☐ Nuraing		URY AT	eldence		(Specify) CRIBE HOW II	HIEV OC	CHIDED	
2 2		Pending Investigation	(Month, D	ay, Ybar)		INJUI	RY .	WO	RK7 ES 2	NO	200. DEŞ	CHIBE HOW II	NJORT OC	CONED	
COMPLETED	3 Suicide 6 4 Homicide	Could not be determined	26e. PLACE O building,	F INJURY - etc. (Specif)	— At home,	, farm, str	eet, fectory	, office			28f. LOCA City o	ATION (Street a or Town, State)	nd Number	or Rural F	loute Number,
7	200. CERTIFIER	TIFYING PHYSIC	CIAN: To the best of	my knowled	dge, death	occurred	at the time	, date	end place	end due	to the cau	se(e) end man	ner as ata	ted.	
5) end manner as stated.
u u	296. SIGNATURE AND TITLE	or distribut	1011	(M)	A	Her	dia)	29c, LICE	NSE NUM	BER 19 >	P	29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF				_		0.					<u> </u>		0	2)1113
	31. DATE FILED (Month, Day	FELDM		301 S		AUL	PL. =	牛4	077	1	3ALT	D, MI	>.2	120	а
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Fage 6 may be retained by the hospital or attending physician.

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	1 - FOR STATE REGISTRAR		STATE OF M	IARYLAND C	/ DEPAR	RTMENT	OF H	IEALTH DEAT	AND I	MENT	AL HYGIEN					
	t. DECEDENT'S NAME (First,	, Middle, Last)									E OF DEATH		7-27	3. TIME (OF DEATH	
	ANNA M.		AGNANO							Mon	NAY	03	1995		8 DI	NH
	4. SOCIAL SECURITY NUMB	ast birthday)	IF UNDER	1 YEAR	IF UNDER		7. DAT	E OF BIRTH			NPLACE (St	ate or Fore	ign			
9	077-16-1517 ¹□M²\XF 78					MONTHS	DATS	HOURS	MIN.	Jul	y 26, 19	16	00000		aly	
	90. FACILITY NAME (If not in				OR LOCATION	ON OF DE	EATN		9c. COI	UNTY OF E	HTAGO					
Ö	Potomac Val		Roc	kvi.	lle				Moi	ntgor	nery					
EC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.							10d. INSI								
5							1XX YES	TS?	0							
AL	10e. STREET AND NUMBER						101	ZIP CODI	E			10g. CI	TIZEN OF	WHAT COU		
Ë	11502 Stone	wood L	ane					2085	2			Uni	ited	State	es	
5	11. MARITAL STATUS 1 Never Married 2 X		12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT O	F NISPAN	VIC ORIG	ilN? (Specify Ye o Rican, etc.)	s or No-	14. RAC	E — Americ	en Indian,	,
Β¥	3 Widowed 4 Divo		IF YES, GIVE W					2 X NO			o riicani, etc.)		Spec	elfy:		
	15. DEC	EDENT'S EDU	CATION	16a. D	ECEDENT'S	LISUAL O	CCUPATIO	nN		14	6b. KIND OF BU	CINECCIIN	DUCTON	MU	ite	
E	(Specify only Elementary/Secondary (0	highest grade	completed) Cotlege (1-4 or 5 +		Give kind of le. Do NOT u	work done	during mo	st of working	g	"	DO. KIND OF BO	SINESS/IN	DUSTRI			
릴	12	-			usewi	fe					Own Hor	ne				
COMPLETED	17. FATNER'S NAME (First, Mi	iddle, Last)						16. MOTH	HER'S NA	ME (First	, Middle, Meider	Surneme)				
BE		tamura						Bar	bara	Anr	na Test	ini				
2	194. INFORMANT'S NAME (7)		L								mber, City or Tow					
	Paul Agnano (husband) 11502 Stonewood Lane, Rockville, MD 20852															
20e. METHOD OF DISPOSITION 1					Lle, Maryland											
	21. SIGNATURE OF FUNERAL		CENSEE / /	Miesa	peake	Lre	MATO AME AN	ry D ADDRES	SS OF FA	CILITY	p ReTi	SVIJ	lle,	Mary.	land	_
		// /	2 111.	/							ices,					
	23 PART i. Enter the di	seeses or o	completions that	Sevend the d	00827	93	33 G	ist P	ve,	511	ver Sp	ring	, MD			
	enock, or ne	ert fellure.	Liet only one ceus	e on each lin	e.	not enter	the mo	da or dyi	ng, suci	n ma ce	rolac or reap	iratory as	rreet,	inte	roximate	ween
Î	iMMEDIATE CAUSE (Fin disease or condition		. Huntin	at on to	Dico	200								1	et and E)aath
	reaulting in death)			OR AS A CONSI										У	ears	
z			b.											j		
RTIFICATION	Sequentially list condition if any, leading to immediate	ona,		OR AS A CONSE	QUENCE O	F):										
CA	cause. Enter UNDERLYill CAUSE (Disease or Injur		с													
F	that initiated evente resulting in death) LAST		DUE TO (OR AS A CONSE	QUENCE O	F):										
CER			d											-		
	PART II. Other eignifical	nt condition	s contributing to	deeth but not	reauiting	in the un	derlying	ceuse g	jiven in	Part i.	24a. WAS AN		24b	. WERE AUT		
5	<u>Cachexia</u>										PERFO			COMPLETE	PRIOR TO ON OF CAU	
PART II. Other eignificant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. Cachexia 24a. WAS AN AUTOPSY PRAFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY NORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK? 1 YES 2 NO 28. DATE OF INJURY AT WORK?																
								^								
В	2 Sudetde	nvestigation	280. PLACE OF	INJURY — At h	ome, tarm,	street, fact			, NO	26f. LO	CATION (Street	and Numbe	v or Rumi I	Boute Numb		
COMPLETED		Could not be determined	building, e	ec. (Specify)			,,				y or Town, State		or riural l	CONTRACTOR OF THE PARTY OF THE	··,	
LE.	290. CERTIFIER 1 X CERTI	IFYING PNYSH	CIAN: To the best of r	my knowledge d	eath occurr	ad at the st	me det-	and elec-	and du-	to the -	augusta) and co-		ete et			
ME			R: On the besis of ex											s) end menr	or os state	ed.
2											,, **			,		-

Ia. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
YES 2 NO	COMPLETION OF CAUSE DF DEATH?
	1 TYES 2 TYNO

29d. DATE SIGNED (Month, Day, Year)

May 4,

WORK?	200. DESCRIBE NOW INJURY OCCURED
tory, office	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

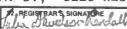
2 MEDICAL EXAMINER: On the besis of examination and/or inve	eatigation, in my opinion, death occured at the time, data end place, end	d due to the cause(s) end menner es stated
29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d DATE SIGNED (Month Day World

D 31319

WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

S. Albiol, Μ. D., 8218 Wisconsin Avenue, #105, Bethesda, MD 20814 Loreto

MAY 08 1995



1995

* T

A	mended FOR STATE REGISTRAR	T						
	1. DECEDENT'S NAME (First	, Middle,						
	JOHN F.	AGNI						
	4. SOCIAL SECURITY NUMBER							
	066-01-418	0						
	90. FACILITY NAME (If not in	stitution,						
5	Manor Car							
5	RESIDENCE OF DEC	10b. CO						
Dinector	New York	Bı						
7	10e. STREET AND NUMBER	201						

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

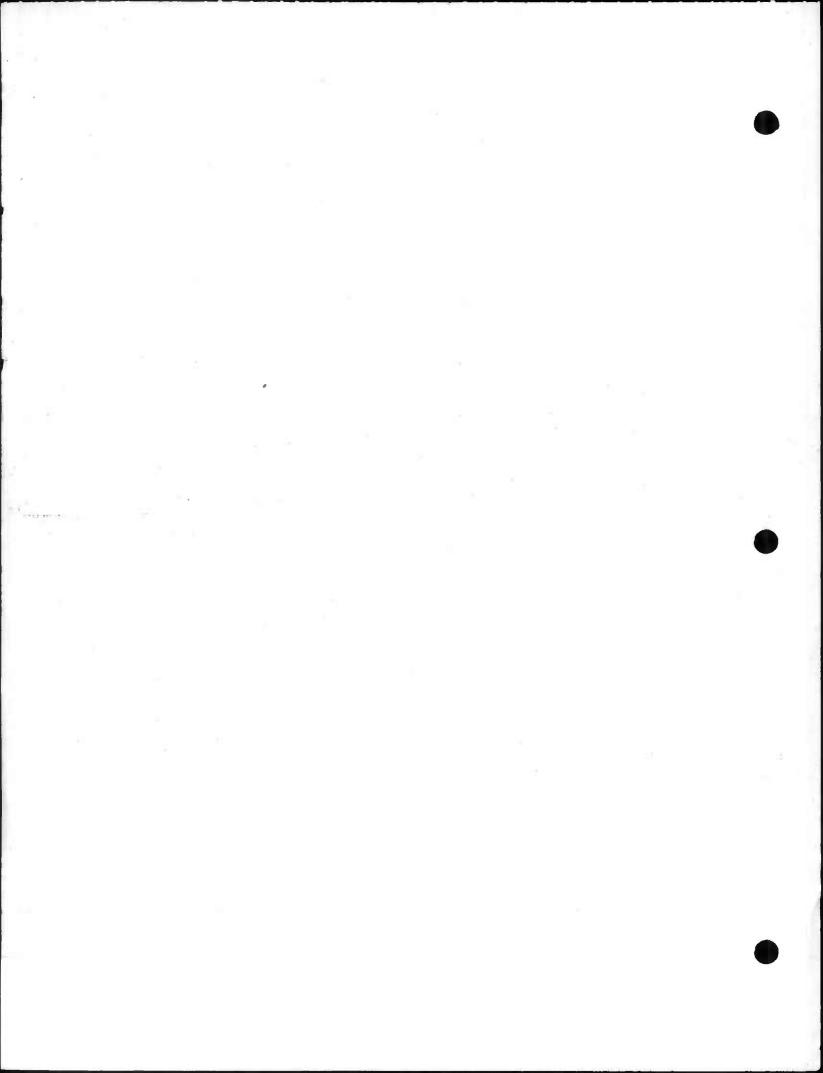
12 DATE OF DEATH

95, 15867 Jounty

	1. DECEDENT'S NAME (First)									2. DATE OF DEATH	W 40	○ ¥EAR	3. TIME OF DEATN
	JOHN F.									April 21	, 19		4:05 pm м
	4. SOCIAL SECURITY NUMBER	, Control	5. SEX	6. AGE (in yrs. las		IF UNDER	DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1.0	Country	PLACE (State or Foreign
	066-01-418		1 X M 2 F	83	YRS.					01704719			ew York
Œ	Manor Car						toma	OR LOCATI	ON OF DI	EATN		nty of DE	
[윤	RESIDENCE OF DEC		illac			10	COM	ac			FIO.	ntgon	liery
DIRECTOR	New York	10b. COUNTY			-	Y, TOWN	OR LOCA	NTION					10d. INSIDE CITY _LIMITS?
	10e. STREET AND NUMBER	Bron	х		DI	onx	_						1 YES 2 NO
FUNERAL	314 East		reet				10	1045	_				States
5	11. MARITAL STATUS 1 XNever Married 2		12. WAS DECEDEN	T EVER IN U.S. AR	MED					NIC ORIGIN? (Specify Yes	or No-	14. RACE Black	- American Indian, , White, etc.
ВУ	3 Widowed 4 Divo		IF YES, GIVE Y	WAR OR DATES				S 2 XNO				Specif	
E	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)	(G	CEDENT'S	work done	during m	ION lost of working	ng	16b, KIND OF BUS	SINESS/INC	DUSTRY	
COMPLET	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Cler					Private	e Bus	sines	ss
ш	17. FATHER'S NAME (Flist, M Peter Agne							16. MOT		y Ann McCal			
TO B	190. INFORMANT'S NAME (7) Peter J.									Route Number, City or Town 1ver Sprin			and 20903
	20a, METHOD OF DISPOSIT 1 X Burlel 2 Cremetto 4 Donetton 5 Other	n 3 🗌 Remo	oval from State	20b. PLACE /	AND DATE I	of Dispos	SITION AP	111 2	27, 1	995 TE 20c. LO	cation -	City or Tox	wn, State ens, New Yorl
	21. SIGNATURE OF FUNERA		ENSEE	001	aly	22.	NAME A	ND ADDRE	SS OF FA	Robert	Pump	hrey	Funeral Home Wisconsin
	► / hicke	e 9	Kull		0348	F	ven	ue, E	sethe	esda, Maryl	and	Z0814	wisconsin 4-3501
	23. PART I. Enter the d shock, or h	iseeses, or c eart fallura. I	ompiidations the List only one car	it coused the de	sth. Do r	not enter	r the m	ode of dy	ing, suc	h as cerdiec or respi	ratory sn	rest,	Approximate Interval Batween
	IMMEDIATE CAUSE (Fir disease or condition	nal		A 0						0			Onset and Death
	resulting in death)	→ ,	DUE TO	(OR AS A CONSE	DUENCE OF	Va	sen	Man	ace	e den			3 wh
z				cue	LL.	W	20	nea	- ae	adam			Corner
OT.	Sequentially list condition if any, leeding to imme	diete	DUE TO	(OR AS A CONSEC	DUENCE OF	F):				enden			
10 P	CAUSE (Disesse or Inju		DUE TO	OR AS A CONSE	MENCE	<u> </u>	an	her	esil	un.			20 4
CERTIFICATION	that initieted events resulting in deeth) LAS	T .	J	(OF AS A CONSEC	JOENCE OF	r j:	_						
	PART II. Other significa	nt condition	contributing to	deeth but not r	esulting	In the u	nderlyir	ng cause	givan in	Part I. 24a, WAS AN		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
EDICAL										1 TES 2			COMPLETION OF CAUSE OF DEATH?
ME													1 TYES 2 NO
N.	DID TOBACCO U		IBUTE TO CA					AV	ERTAII	NO			
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO	O MEDICAL	HOSPITAL:	26. PLAC	DOA	OTHE	R:		esidence	6 ☐ Other (Specify)			
Ή	27. MANNER OF DEATH	et .	28e. DATE OF (Month, D		28b. TIM		28c. tN	JURY AT ORK?		28d. DESCRIBE NOW II	NJURY OC	CURED	
ВУ		Pending Investigation				М	1 🗌	YES 2	NO				
		Could not be determined	28e. PLACE C building,	F INJURY — At ho etc. (Specify)	me, term, s	street, fec	tory, offic	ce		28t, LOCATION (Street e City or Town, Stelle)	and Number	or Rural R	oute Number,
COMPLETED										to the cause(s) end man time, date end place, en			end manner ee stated.
E C	29b. SIGNATURE AND TITLE								ENSE NUI				(Month, Day, Year)
Φ	h	am	- two	nech	2			173	5-	047			-91
5	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DEATH (ITE	4 27) (Type,	Print)				77.7			
					Mas	sach	uset	ts A	venu	e N.W., Wa	shin	gton,	D.C. 20016
	31. DATE FILED (Month, Day,	8 1995		R'S SIGNATURE									
	ITIAI U	~ 1992	Spelied	wales Par	dall								DHMH-16 Rev 1/89

12+

DHMH-16 Rev 1/89

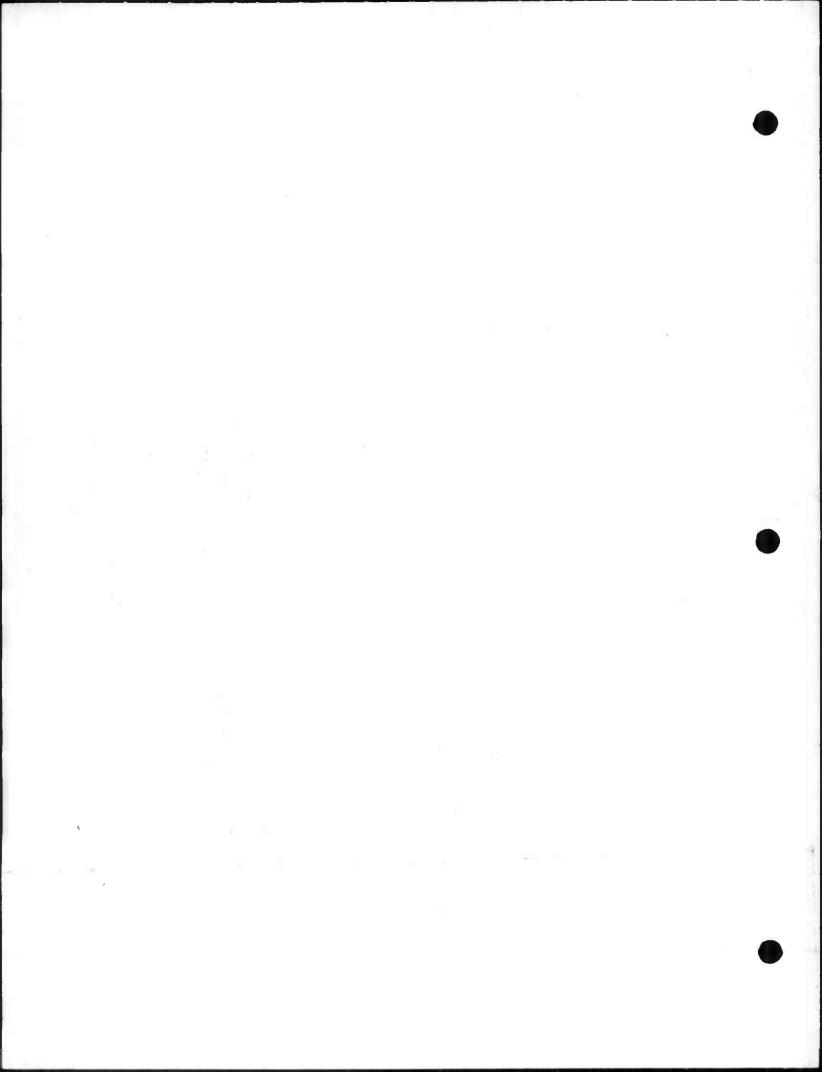


DIVISION OF VITAL RECORDS

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	Middle, Last)									2. DATE	OF DEATH		3	. TIME OF DEATH
		Ma	arion	R.			An	derse	-η			MONTH	D/I	995	YEAR	L2:01 A M
		4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE	(In yrs. lest		#F UNDER		IF UNDER	24 HRS.	7. DATE (OF BIRTH	-	s. BIRTHPL	ACE (State or Foreign
		578-44-475	8	1 🗆 M 2 😿 F		85	YRS.	MONTHS	DAYS	HOURS.	MIN.		4, 19	09	I OWa	
pinous	100	9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CITY	, TOWN	OR LOCATI	ON OF DE				TY OF DEA	TH
2,3	CTOR	Rockville N		g Home					Ro	ckvi.	lle			Mo	ntgon	nerv
-		RESIDENCE OF DEC	10b, COUNT	γ			10e CIT	Y, TOWN C	N 1 0 C 4	TION						
Pages	E E	Maruland								IION						Dd. INSIDE CITY LIMITS?
permit.	1	Maryland 10e. STREET AND NUMBER	Montg	omery			Ве	thes	-	H. ZIP CODI	F			10a CITIZ		T COUNTRY?
*	FUNERAL	8619 Lanca:	ctor D	mirro					1							
020 physician. burial-transit	N N	11. MARITAL STATUS	ster D	12. WAS DECEDEN	IT EVER I	N U.S. ARA	MED	13.	WAS DEC	2081		IIC ORIGIN	? (Specify Yea	Unite		ates - American Indian.
		1 Never Married 2 🔀		FORCES? 1			0		if yes, sp	ecify Cuba	n, Maxica	n, Puarto R	ican, etc.)		Black, Y	White, etc.
215-0020 attending physic se as the burial	ВУ	3 Widowed 4 Divo	roed	X						, 1 <u>M</u> 100	opecin	,			Specify:	White
att as	TED	15. DECI (Specify only	EDENT'S EDU highest grade	CATION completed)		(Giv	w kind of s	USUAL O	CCUPATE	ON ost of working	10	16b.	KIND OF BUS	INESS/INDU	STRY	
N m b	COMPLET	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	IIIa.	Do NOT us	e retired.)		out or world						
AND the hospit detached	MP		200	5+		Ar	chiv	ist					ederal		rnme	nt
	- 1	17. FATHER'S NAME (First, Mi								18. MOTI	HER'S NA	ME (First, M	liddle, Maiden	Sumame)		
	1 44 1	Irvin E. R:											Hintho			
2 2 2	2		,,,			1							er, City or Town			
1 2 8 E		Nancy L. St					3712	Nor	th F	Road,	3 W	est,	Monte			81144
) w # #		1 Donation 5 Other	n 3 🗆 Rem	oval from State	20b	netery, crem	no DATE (of DISPOS ther place)	ITION (N	^{ame} May	11,	1995	20c. LOC	CATION — C		
Page al direct		21. SIGNATURE OF FUNERAL		CENSEE	- Ar	11ng	ton	Natio	onal	Cem	eter	y CHITY TO	Arl	ingto	n, V	irginia
BAL I IN Ber death. Pag the funeral di mal,		D 1	.00	· D.,				Ног	ne/E	Sethe	sda-	Chevi	Chas	A. Pu	mphre	ey Funeral
. 0 = -		-/ Oa	حلا ح	lem	4.	MO(0803	Wis	scon	sin :	Aven	ue. F	Rethes	da. M	arvla	and 20814
		23. PART I. Enter the di shock, or he	sesses, or c sert fallure.	complications the List only one cau	t daused	d the dee	th. Do r	ot enter	the mo	ode of dyl	ng, aucl	h as cardi	lec or respir	ratory arre	st,	Approximata Interval Between
		IMMEDIATE CAUSE (Fin	ai			0										Onset and Desth
		disesse or condition resulting in death)	→	· liu	rer	fa	ilur	e								years
B 2 - 8					110	CONSEC		•								
at pring of	NO N	Sequentially list conditi	ona,			CONSEC										Years
or ior ior	RTIFICATION	If any, lasding to immed cause. Enter UNDERLYII		502 10	(On AS A	CONSEC	DENCE OF	·):								
e by at	윤	CAUSE (Disease or Injure that initiated events	ry	C. DUE TO	(OR AS A	CONSEC	UENCE OF):								
	E	resulting in death) LAST	T													
- E S -	5			s												1
7 2 3 2 7	DICAL	PART II. Other significan					euiting i	n the un	derlyin	g ceuse g	iven in	Part I.	24s. WAS AN /			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ulres that signed by Health an		Congest	rive 1	heart	fail	ure						_	1 YES 2	Тио Т		OMPLETION OF CAUSE F DEATH?
requires been sign of Healt	- 1											_			1	☐ YES 2 THO
law law as be as bept.	AN	DID TOBACCO US		RIBUTE TO CA					_	₹ UNC	ERTAIN	10		10		
SICIAN: The law requestricate has been to the State Dept. of the 23 should be supply of the supply o	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE		OTHER	t:							
CLAN Sertific	17.5	1 YES 2X NO		1 Inpetient 2		etlent 3		4 🖾 Nun	ing Hom	ne 5 □ Ra	sidence					
子 等 等 全	РНУ	1X Netural 5 S	Pending	(Month, D			28b. TIM	URY M		PRK?	140	28d. DE\$0	CAIBE HOW IN	JURY OCCU	RED	
After death		2 Accident	nvestigation	28e. PLACE O	E INJURY	- At hom	a farm a			YES 2	NO	****	T1011 (0)			
DR ATTENDING DIRECTOR: After hours after death tem 28 is ma	8		Could not be letermined	building,	etc. (Spec	cify)	re, rarrii, i	eroot, mete	эгу, отне	•		City o	TION (Street at r Town, State)	nd Number o	' Rural Rout	a Number,
DIRECT HOURS		29a. CERTIFIER Y						. :-								
보 기가 보		(Check only 145 CERTI		CIAN: To the best of												
HOSPITAL FUNERAL within 72	8				kaminetio:	n and/or In	ventigatio	n, in my o	pinion, d	leath occun	ed at the	time, data s	and place, and	dua to the	cause(s) ar	nd manner as stated.
To the Hospit To the Funera De filed within 7	B	296, SIONATURE AND TITLE	OF CERTIFIEF	1 1/2	Park	A				29c. LICE	NSE NUM			29d. DATE	SIONED (M	onth, Day, Year)
255	2	a	NA	01.10	-0-31)	14	0			0	239	711		M	lay 8	, 1995
.)		30. NAME AND ADDRESS OF							_							
18		David A. Bla	ass, M	32 SECISTRA	O OT	a Ge	orge	town	Roa	ad, B	ethe	sda,	Maryl	and 2	0814	
		31. DATE FILEO (Mogity Pay	9 1991	Julia d	huselin	or Ran	1.11									
				(/			- qual									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. The hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

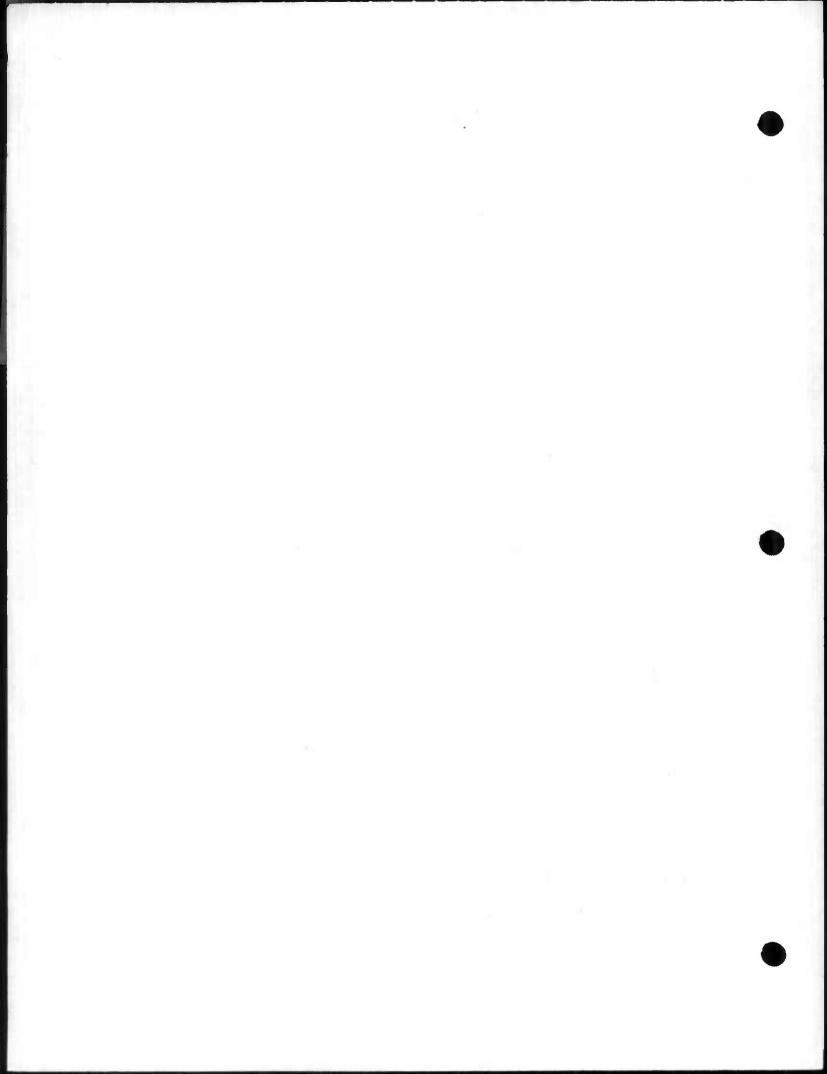
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

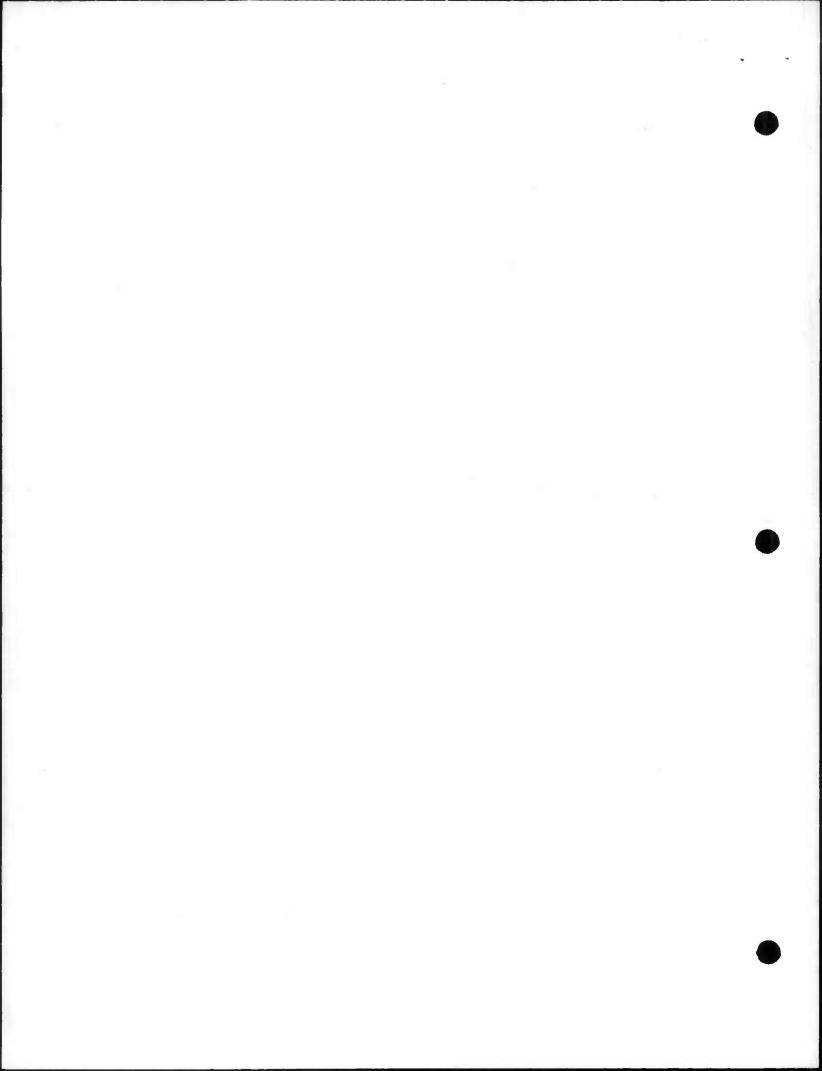
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Middle, (ast)	Poter +	10000	4 1,				L	ATE OF DEATH	AY_	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	injuly	JEIEI /	reaci	1,51				- 1	124 8;1	995	7	/ T M
			5. SEX 1-√2 M 2 ☐ F	6. AGE (In yrs. Ia	st birthday) YRS.	IF UNDER	1 YEAR	HOURS	BANK .	(Month, Day, Year)		Country	
	189-30-668		22	56	THS.					May 12, 19	_		sylvania
œ									ON OF DEA	тн		NTY OF D	
DIRECTOR	7333 New Ha	mpshir	<u>e Avenue</u>	#1000		Ну	att	svill	.e		Prin	ce G	eorge's
ĕ.	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCA	TION				T	10d. INSIDE CITY
5	Marvland	Prince	George'	S	Hya	attsv	111	e				I	LIMITS?
AL	10e. STREET AND NUMBER							. ZIP CODI	E		10g. CIT	ZEN OF W	VHAT COUNTRY?
FUNERAL	7333 New Ham	npshire	Avenue	#1000				207	83		l t	.S.A	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT C	F HISPANIC	ORIGIN? (Specify Yes	or No-	14. RACE	— American Indian, White, etc.
ВУ Б	1 X Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y		NO				n, Mexican, Specify:	Puerto Ricen, etc.)		Speci	
												Whi	te
	(Specify onl	EDENT'S EDU		16a. D	ECEDENT'S Give kind of e. Do NOT u	work done	during mo	ON est of working	ng	16b, KIND OF BU	SINESS/INC	DUSTRY	
1 5	Elementary/Secondary (0)-12)	College (1-4 or 5	*'		se remea.,				Daldada.			4
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)	4	Tea	cher		_	18 MOTI	IED'S NAM	Religiou		ucat	1011
	Stanley Pet	er Arh	ach. Sr							et E. Rich			
BE	190. INFORMANT'S NAME (7		den, br.		9b. MAILING	ADDRESS	(Street	-		ute Number, City or Tow		_	
임	Jessica L.	Clark		1	0421	Flor	al I	Orive	Ade	elphi, Man	rv1an	d 2	0783
	20a. METHOD OF DISPOSIT	ION		20b. PLACE	AND DATE	OF DISPOS	_				CATION —		
	4 Donation 5 Other		oval from Stata	_ cemetery, cr Metro	polit	ther place) an C	rema	atory	5	10/95Alex	kandr	ia,V	irginia
	21. SIGNATURE OF PUNERA	L SERVICE LIC	ENSEE			22.	NAME AI	ND ADDRE	SS OF FACE				
	1 (101H)	1) 16	Touch							Blvd.,W.			
	23. PART I. Enter the d	Iseasea, or o	omplications the	t caused the d	eeth. Do	not anter	the mo	de of dy	ng, auch	as cardled or respi	ratory an	rest.	Approximate
	ahock, or h IMMEDIATE CAUSE (Fir	eart fellure.	List only one car	use on each lin	e.								Interval Between Onset and Death
	disease or condition resulting in death)	→	Ethy	(OR AS A CONSE									
	readiting in deatily		DUE TO	(OR AS A CONSE	OUENÇE O	F):							
z	Sequentially list condit	ione C	b										
CERTIFICATION	if any, leading to imme	diste	DUE TO	(OR AS A CONSE	OUENCE O	n:							
음	CAUSE (Disease or inju		DUE TO	(OR AS A CONSE	OUENCE O	FI-							
Ē	that initiated events resulting in deeth) LAS	Т		(0.11.10.11.00.11.02	. OOLITOE O	,.							İ
핑			1										
AL	PART II. Other algnifica		s contributing to	deeth but not	reaulting	in the un	derlyin	g ceuse (lven in P	art I. 24s. WAS AN		24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
MEDICAL	ANNUN	<i>la</i>								1 _ YES 2			COMPLETION OF CAUSE OF DEATH?
WE										_ 1			1 TES 2 NO
	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DEA	ATH YI	S 🔲 1	10 E	UNC	ERTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLA	CE OF DEA	OTHER			/				
IXS	1 VES 2 NO		1 Inpetient 2		1	4 - Nun	ing Hom			☐ Other (Specify)			
		Pending Investigation	28e. DATE OF (Month, E	ay, Year)	28b. TIM	E OF JURY M		URY AT PRK? YES 2	- 1	28d. OEŞCRIBE HOW I	NJURY OC	CURED	
Э ВУ	2 Calabia	Could not be	28e. PLACE C	F INJURY — At b	ome, farm,	street, fact			_	281. LOCATION (Street	and Number	or Rural R	loufe Number,
E		determined	Donaing,	etc. (Specify)						City or Town, State)			
PLE	29e. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowledge, d	eath occurr	ed at the t	me, date	end place,	end due to	the cause(s) end mer	ner ee stat	ed.	
COMPLETED	one) 2 MEDI	ICAL EXAMINE	R: On the beels of e	xamination end/or	Investigation	on, In my o	pinion, d	esth occur	ed at the ti	me, date and place, en	d due to it	e ceuse(e)	end menner ee stated.
BE	Jugus To	OF CERTIFIEF	Podicke	ces N.	m			29c. LICE A 21	NSE NUMB	ER /	Jog DAT	SIONED	(Month, Day, Year)
2	A COCUSTO A	PERSON WH	COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type	Print)	1	1111	NIC	7, 8,	n)	1//	16
	31. DATE FILEO (Month, Day,	Your)	32. BEGISTRA	AR'S SIGNATURE	300	114	-JM	MIL	1	p.JM.	110	207	40
	MAY 1	1 1995	Julia d	audion Ro	rdall				V	V		,	

DIVISION OF VITAL RECORDS, P.O. BOX 68760



_	_	1 - STATE REGISTRAR	STATE OF MAR					EALTH DEAT			YGIENE EG. NO.			
		t. DECEDENT'S NAME (First, Middle, Last BRANDON	WAYNE				ABB	OTT		2. DATE OF DEMONTH	DEATH DAY		YEAR	1:00 A
		4. SOCIAL SECURITY NUMBER		GE (In yrs. les	t birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF B				NCE (State or Foreign
pino	į	218-43-8174 9a. FACILITY NAME (If not institution, give	1 M 2 F		YRS.	3				Feb.	12]		Mar	yland
3 should	E	2815 PATAPSCO							ON OF DEA	TH			TO T T	
3 1, 2,	5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN					NKSB					CAR	KOLL	COUNTY
Page	DIRECTOR		Carroll				or locati ksbu							d. INSIDE CITY LIMITS?
er air.	. 1	10s. STREET AND NUMBER	2411011			г ди		ZIP CODE				10g. CITIZ		YES 2 NO
n. ansit p	FUNERAL	2815 Patapso	o Rd.				2	104	8			U	.S.A	
of the ph	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 1	MED		WAS DECI If yes, spe 1 YES	cify Cubar	F HISPANIC n, Maxicen, Specify:	ORIGIN? (S _i Puarto Rican	pecify Yes i, etc.)		4. RACE Black, W	American Indian
215 attend se as	요	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	18a. DE	CEDENT'S	USUAL O	CCUPATIO	N st of workin	-	16b, KIN	D OF BUSI	NESS/INDU	STRY	
4 <u>8</u> 8	COMPLETE	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	se retired.)	during mos	st or working						
	_ 11	17. FATHER'S NAME (First, Middle, Last)	Abbott T	20						E (First, Middle				
E 8 20	BE	Kenneth Wayne	ADDOCE J		b. MAILING	ADDRES				e M. ute Number, C			*adel	
be retain ge 5 sho	2	Kenneth W. Ab	bott							Finks				1048
ORE, e 6 may be ector, page must be		20a. METHOD OF DISPOSITION 1 Sy Burlal 2 Cremation 3 Re	noval from State	20b. PLACE A	ANDDATE	OF DISPOS	SITION (Ner			DATE			ty or Town,	
IMORE Page 6 may all director, page		4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L		Pata) Ce	met	ery	S OF FACI	5/13			co, l	
death.		Many J.	Flatcher.			2	54 E	E. M	ain	Stre	et,	West	mins	al Home ster,Md.
within 24 hours pletely filled in t cremation, or re-		23. PART I. Enter the diseases, or shock or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Sudden	n aach lina	•							atory arre	nt,	Approximate interval Between Onset and Death
P.O. BOX 68' th certificate be execute ending physician and co I Hygiene prior to buna or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR A c. DUE TO (OR A d.											
RDS, F hat the death I by the atter and Mental NY Injury, C		PART II. Other eignificant condition	ns contributing to deat	h but not r	eaulting	In tha ur	ndarlying	causa g	ivan in Pr	art I. 24a.	. WAS AN A			RE AUTOPSY FINDINGS
equires the signed of Health hows an	MED	DID TOBACCO USE CON	TRIBUTE TO CALLE	OF DEA	*11 V/F			111100		_ ′	PERFORM		COI OF	ALABLE PRIOR TO MPLETION DF CAUSE DEATH? XYES 2 \(\text{NO}\)
TAL F The law ite has be ate Dept.	AN	25. WAS CASE REFERRED TO MEDICAL	IKIBUTE TO CAUSE		E OF DEAT			UNC	ERTAIN					
F VITAL SICIAN: The learning the State Dr. 16m 2	2	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/C	Outpatient 3	□ DOA	OTHER		5X Me	sidence 8	☐ Other (Spe	ic/fv)			
집 = > 근 .	BT PHTSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJUI (Month, Day, Yes		28b. TIM INJ		28c. INJU WOR	JRY AT	2	88d. DEŞÇRIB		JURY OCCU	RED	
TISIC TTENDI TTE	3	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJI building, stc. (5	URY — At hor Specify)	me, farm, s	street, fact	ory, offica		2	City or Tow	N (Street an vn. State)	d Number o	Rurel Route	Number,
	COMPL		ER: On the beat of my kr											d manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	H H	296. SIGNATURE AND TITLE OF CERTIFIE	2. Chute m						NSE NUMB					nth, Day, Year) 1 , 1995
		30. NAME AND ADDRESS OF PERSON W		11			Str	eet,	Ba	ltimo	re,	Mar	ylan	d 21201
		31. DATE FILED (Month, Day, Year) MAY 1 2	1995 Julia	Audior	Renta	Ц								DHMH-18 Ray 1/8



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

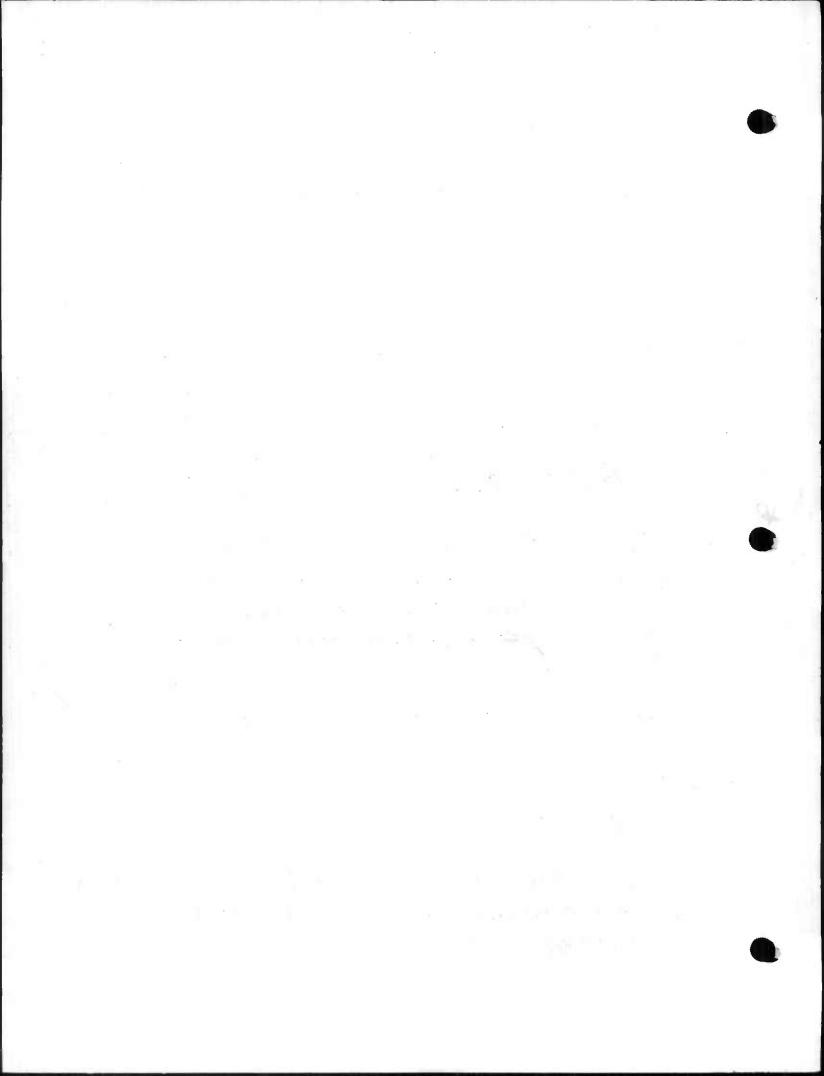
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	CERTIF	ICATE O	DEAT	H	REC	a. NO.			
- 8	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE				3. TIME OF DEATN
	Vivian Dake Armstrond	3				May	1	0. 1	995	11 A.M. M
		. lest birthday)	IF UNDER 1 YEAR	IF UNDER 2		7. DATE OF BIR (Month, Day,	TN	<u> </u>	8. BIRTN	IPLACE (State or Foreign
	073-05-2800 1 ⅓M 2 □ F 88	YRS.	MONTHS DAYS	HOURS	MIN.	Dec. 2	9,1	906	Penn	sylvania
-	9e. FACILITY NAME (If not institution, give street end number)		96. CITY, TOWN	OR LOCATIO	N OF DE	ATH			NTY OF D	
DIRECTOR	324 Clyde Ct.			Abingd	on				Harfo	ord
ᇤ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c CIT	Y, TOWN OR LOC	ATION						10d. INSIDE CITY
뜽	Maryland Harford		ngdon	A. I.O.I.						LIMITS?
	10e. STREET AND NUMBER	LADI		Of. ZIP CODE				10a CIT	TZEN OF V	1 ☐ YES 2 🌠 NO VHAT COUNTRY?
EB	324 Clyde Ct.		1 3	21009						
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS DE	CENDENT OF	NISPANI	IC ORIGIN? (Spec	Ify Yee		14. RACE	tates
	1 Never Married 2 Merried FORCES? 1 YYES 2 IF YES, GIVE WAR OR DATES	□ NO	If yes, s	pecify Cuben,	Mexican Specify:	, Puerto Rican, e	tc.)		Black Specif	t, White, etc.
BY	3 Wildowed 4 Divorced WW II									ite
COMPLETED	15. DECEDENT'S EDUCATION 16e (Specify only highest grade completed)	(Give kind of)	USUAL OCCUPAT	ION nost of working		16b. KIND	OF BUS	INESS/INI	DUSTRY	
빌	Elementary/Secondary (0-12) College (1-4 or 5+) 3 Years M	ille. Do NOT us	™ rottrod.) Picture	Engin		Libno		05 0		
N	17. FATHER'S NAME (First, Middle, Last)	OLION	ricture						ongr	ess
	Hartley Wilson Armstrong					RE (First, Middle, I				
BE	19a. INFORMANT'S NAME (Type/Print)	10h MAILING	ADDRESS (Street	E11a				ith		
2	Robert D. Armstrong		lyde Ct) Code)	
1	20e. METNOD OF DISPOSITION 20b PLA		OF DISPOSITION //		iguoi				City or Tox	wn Riete
	1 LX Buriel 2 Cremetion 3 Removal from State Cametary	cremetory or or			5/	13/95 S				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME	AND ADDRESS	OF FAC	HLITY	out	11 04	Hauli	,1 a .
	+ Stroke a Idean					al Home				
	23. PART i. Enter the diseases, or complications that caused the	death Do r	1 1 3 1 /	Cokes	bury	y Rd. A	bin	gdon	, Mo	d. 21009
	shock, or heart feliure. List only one ceuse on each immediate cause (Final	lina.	. 1		,	-	respir	atory ar	wat,	interval Between Onset and Death
	disease or condition	wh	. H	ast	to	le o				CV4
	resulting in death) a. DUE TO (OR AS A CON	EQUENCE OF	7: ~	^	0.	-000			-	03
Z	De De		mit	of R	el	verto	le	~		year.
E	Sequentially list conditions, if any, leading to immediate	SEQUENCE OF	ŋ:	,	0	0				0
5	cause. Enter UNDERLYING CAUSE (Disease or Injury									
Ē	that initieted events resulting in deeth) LAST	SECUENCE OF	·):							
CERTIFICATION	d									
	PART ii. Other algnificent conditions contributing to death but no	ot resulting l	n the undarlyi	ng cause gi	van In F	Part i. 24s. W	AS AN	WTOPSY	24b.	WERE AUTOPSY FINDINGS
DICAL							ERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH
ME										1 🗆 tes a tro
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH YE	S NO [UNCE	RTAIN					100
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. P. HOSPITAL:	LACE OF DEAT	H (Check only one OTHER;)	/					
IXSI	1 TYES 2 PNO 1 Inpetient 2 ER/Outpatient		4 - Nursing Ho		dence 6	Other (Specif	y)	,		
	27. MANNEB OF DEATH 28e. DATE OF INUURY (Month, Day) (Ser.)	28b. TIN	URY W	JURY AT ORK?		26d. DESCRIBE	HOW IN	HURY OC	CURED	
B	2 Accident Investigation	101		YES 2 E				100		
	3 Suicide 8 Could not be determined 200. PLACE OF INJURY — All building, etc. (Specify)	Ma	nreet, ractory, om	Ce		28f. LOCATION (City or Town,	Street	nd Number 1	or Rural R	oute Number,
9 h	29a. CERTIFIER	10					<u></u>			
COMPLETED	(Check only CERTIFYING PHYSICIAN: To the beat of my knowledge,	death occurre	d at the time, dat	e end place, e	and due to	o the cause(a) as	nd man	ner ea stal	led.	
8	one) 2 MEDICAL EXAMINER: On the beels of examplation end	or investigatio	n, in my opinion,	death occured	at the ti	ime, date end pla	ice, enc	due to in	a caused	and manner ea stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICEN	SE NUME	BER /		29d. D.O	SIGNED	of Congress
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (TEM 27 /T-	Out-en	NIG	00	0		-0	110	17/
	Deal Vassay MD 1110		ee Rd	46 11	(·	RIM	111	100	1/2	1015
-	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATUR		ecku,	JEC 11	U	BelA	IV,	7 7 1	12	1015
	MAY 1 2 1995 Sabi discharles	A.A.								İ

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIFIC	ATE O	F DEATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN
		Hen	rietta		Berrv		May 1		F 00 - 11
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (F UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	-	RTHPLACE (State or Foreign
		722-18-7504	1 🗆 M 2 😡 F	75 YRS. M	ONTHS DAY	8 HOURS MIN.	(Month, Day, Year)	Co	untry)
Pino		Be. FACILITY NAME (If not institution, give si		/)	h CITY TOW	N OR LOCATION OF DE	02/11/20	9c. COUNTY O	rginia
3 should	α						AIN		
2,	유	Frederick Memo	πιαι πολρι	tal 1	reae	enick		trec	derick
S		10s. STATE 10b. COUNTY		10c, CITY,	TOWN OR LO	CATION			10d. INSIDE CITY
Pag	DIRECTOR	Manyland Fre	derick	В	runsu	vick			LIMITS?
permit. Pages		10e, STREET AND NUMBER			1	101. ZIP CODE		Lan OITITEN C	1 X YES 2 NO
8	RA		,						OF WHAT COUNTRY?
physician. burial-transit	FUNERAL	42 West & Stre				21716		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
physician burial-tra	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 TYES	1 U.S. ARMED	13. WAS !	DECENDENT OF HISPAN specify Cuban, Maxican	IC ORIGIN? (Specify Yes	or No — 14. R.	ACE — American Indian, llack, Whita, atc.
	B	3 € Widowed 4 Divorced	IF YES, GIVE WAR OR D			ES 2 NO Specify		Si	Black
attending se as the			247:041		1				
use use	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of wor life, Do NOT use i	k done during	ATION most of working	16b. KIND OF BUS	SINESS/INDUSTR	4
ftal o	ا ۳	Elementary/Secondary (0-12)	College (1-4 or 5+)				ρ	• . 1 . 11	. 1 5 . 1 . 1
the hospital detached for once.	Σ			Custod	Lan				igh School
	8	17. FATHER'S NAME (First, Middle, Last)	C			A	ME (First, Middle, Maiden	Surname)	
d by	띪	Logan Anderson	., Sr.			Marior	r Powell		
5 should notified	0	19a. INFORMANT'S NAME (Type/Print)	_				loute Number, City or Tow		
5 5	-	Charles S. Ben	ny, In.	42 Up.	shur	Drive, I	Inwood, W	IV 2542	28
nay be		20a. METHOD OF DISPOSITION		PLACE AND DATE OF	DISPOSITION	(Name of	DATE 20c. LO	CATION — City or	r Town, State
leath. Page 6 ma funeral director, p	1 1	1 元 Burlat 2 ☐ Cremation 3 ☐ Rame 4 ☐ Donation 5 ☐ Other (Specify)	1 1/6	etery, crematory or othe	n Men	nomial Go	indens F	nedeni	ick. MD
		21. SIGNATURE OF FLATERAL SERVICE LICE Banbana H	ENSEE //	/ Car	22. NAME				
death. Pag funeral di f. examiner		Buraca	- He www	war.	901	in 1. Wil	liams Fu	ineral	Home
						Petersu	ille Rd.	, Brui	rswick, MD
E B A		23. PART I. Enter the diseases, or c	omplications that caused	the death. Do not	enter the	mode of dying, such	as cardiac or respi	ratory arrest,	Approximata
filled in on, or re		IMMEDIATE CAUSE (Finel	List only one cause on a						interval Between Onset and Daath
the the		disease or condition	Souphase	chnow	o h	enanh	00 1		
completely ial, cremati		resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	ug c		
B 9 =: 0	-	_	DUE TO (OR AS A DUE TO (OR AS A		0 /	has	100		
8 "0 =	CERTIFICATION	Sequentielly list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):	7	meun	Jan-		
Sician prior trau	ΑŢ	if any, leading to immediate cause. Enter UNDERLYING	Homes-	1.0	D	- 1 - 1-			į į
	프	CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	3/	asers			
h certifica ending ph Hygiene or other	E	reaulting in deeth) LAST	TO B	mehia	01	011-	mle	1	
	빙					84ms	O Seri	>	
= 0 =	7	PART II. Other aignificant condition	contributing to death b	ut not resulting in	the underly	ring ceuse given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
= 0 = -	EDICAL						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
sign sign							_ 10 163 3	7110	OF DEATH?
requires seen sign of Heat	Σ	DID TORACCO LISE	CONTRIBUTE TO	CALISE OF	DEATH	VEC ET NO	- -		1 TYES NO
has be Dept.	A	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE OF					
N: The ficate h State	힐	EXAMINER?	HOSPITAL:		THER:	PLACE OF DEATH (Che	ick only one)		
ician ertific the S	ΥS	1 TYES 2 TO NO	1 Inpatient 2 ER/Outp			loma 5 🗆 Rasidenca	6 Other (Specify)		
	PHYSICIAN	27. MANNER OF DEANI 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME (OF 28c.	INJURY AT WORK?	28d. DESCRIBE NOW II	NJURY OCCURED	
DING PHYS After this death with s marked	.≿	1 Natural 5 Pending Investigation			M 1 [YES 2 NO			
R: Al	- Os	3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Spec	- At homa, farm, stre	et, factory, o	ffice	28t. LOCATION (Street a City or Town, State)	and Number or Run	al Route Number,
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	H	4 Nomicide detarmined							
OR A DIREC hours	COMPLET	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death occurred	of the time.	sta and place, and due	to the cause(a) and mad	oper se steted	
PITAL R 72	M		R: On the basis of examination						se(s) and manner as stated
FUNE Within		29b. SIGNATURE AND TITLE DF CERTIFIER							
표표	BE	230. SIGNATURE AND TITLE OF CENTIFIER	11 11			29c. LICENSE NUM	BER	29d. DATE SIGN	NED (Month, Day, Year)
TO THE HOSPITAL (TO THE FUNERAL D DE filed within 72 h IMPORTANT; II II	5	min	42 /00)			12/8/11	4	- 5 -	14-55
	-	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, Pr	int)	C	Con		. 0 -
		JWHMINA	7 HAN	MD 2	07	w 1 m	. FREDE	reich	Med Zen
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN						1
		MAY 1 7 1995	Julia Dave	wor Randall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the 28 begard of the attending physician prior to burial, cremation, or removal.

IMPORTANT: If them 28 its marked, or tiem 23 shows any injury, or other traumaitic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGI REG. I	
1	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	
1	Albert Beckle	v Bover, Sr.	MONTH	DAY

	1. DECEDENT'S NAME (First						-			2. DATE OF DE	ATH			3. TIME OF DEATN
	1		y Boyer,	Sr.						Mav	11		1995	2:30 Am
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		IF UNDER	7	7. DATE OF BIR	TH		8. BIRTN	IPLACE (State or Foreign
	219–36–4205		1 X M 2 - F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	April	17,1	919	Mary	yıand
-	9a. FACILITY NAME (If not if		-11			9b. CITY,		OR LOCATI		ATH		9c. COUN		
DIRECTOR	Frederick		lal Hosp	ıtal			Fre	deri	ck			F	rede	erick
Di Di	10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY
H	Maryland	Fre	derick			Fre	eder	ick						LIMITS?
A P	10e. STREET AND NUMBER						10	1, ZIP COD	E					WHAT COUNTRY?
FUNERAL	228 East	Seven	th Stree	t				21	701				U.S.	.A.
1 5	11. MARITAL STATUS		12. WAS DECEDED	T EVER IN U.S.	ARMED					IC ORIGIN? (Spec		r No—		E — American Indian, k, White, atc.
BY	1 Never Married 2 3 X Widowed 4 Divo			MAR OR DATES	7760			2 NO			ic.)		Speci	
		EDENT'S EDU	CATION	1 160	DECEDENT'S	Heuri or	VOLUBATION OF THE PROPERTY OF	011		441 173100				WIIICG
	(Specify onli Elementary/Secondary (I	y highest grade	completed)		(Give kind of a	work done o	during mo	ost of working	ng	16b. KIND	JF BUSIN	NESS/INU	USTRY	
19	8	J-12)	College (1-4 or 5	*)	P1um	ber				P	lumb	ing		
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)						18. MQT	NER'S NAM	AE (First, Middle, i				
BEC		E	mmert	Воз	/er				Edit	th	W	links		
TO E	19a. INFORMANT'S NAME (- 1							oute Number, City				
	Mrs. Shirle	_	ann						, Fre	ederick				
	1 XBuriel 2 Crematic	n 3 🗌 Ram	oval from State	cemetery,	cremetory or o	ther plece)	ITION (Ne	eme of	~ M-	DATE 2	OE E	TION — O	Offy or To	wn, State K, Maryland
	21. SIGNATURE OF FUNERA		CENSEE	Rest	maven	22.	NAME A	ND ADDRE	SS OF FAC	ord P.A	95 F	reae	ET TC!	R, Maryland
	I ► AP	lan	9/ 0	Que 1	100703									ome MD 21701
	23. PART I. Enter the d			non		1 70								Approximate
	shock, or h	eart fallure.	List only one car	use on each i	ine.					· ao caraido o	reapire	nory arre	par,	interval Between Onset and Daeth
	IMMEDIATE CAUSE (Fir	nai .	PULI	MONA	RY		EN	130	415	M.				5 Days
	resulting in death)		a	(OR AS A CON		F):								
Z	Sequentially list condit	inne C	0.	PVEN			HRO	MB	05/	<i>s</i>				
CERTIFICATION	If any, leading to imme	diata	DUE TO	(OR AS A CON	SEQUENCE OF	F):								
5	CAUSE (Disease or inju		c	(OR AS A CON	SEQUENCE OF	F):	_		-					
E	resulting in death) LAS	т 🖠				,								į v
	DART II Onberedentile													
MEDICAL	PART II. Other signification HYPER To	EAL CAG	S contributing to	death but no	t resulting	in the un	dariyin	g cause (given in I	Part I. 24a. V	AS AN AU		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	1111221	277070			_					_ 10	YES 2	NO		OF DEATH?
	DID TOPACCO II	CE COLIT	DIDLITE TO 64							_				1 TYES 2 NO
AN	DID TOBACCO U		RIBUTE TO CA		LACE OF DEAT	_		JUNC	ERTAIN					
PHYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:			OTHER	1:	- 5						
H	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM		ing Hom 26c. INJ		sidenca	28d. DESCRIBE		URY OCC	URED	
ВУ Р		Pending Investigation	(Month, D	ley, Year)		URY	WO	PRK?] NO				0.120	
	2 Devlates	Could not be	26a. PLACE C	F INJURY — At atc. (Specify)	home, term, a	treet, facto	ry, offic			26f. LOCATION (Street and	1 Number o	or Rural R	loute Number,
TED	4 Homicide	determined		are (opoony)						City or Town	Sraie)			
PL	29a. CERTIFIER 1 CERT	IFYING PNYSI	CIAN: To the best of	my knowledge,	death occurre	ed at the ti	me, date	and place,	, and due t	to the cause(a) a	nd menne	er aa atate	d,	
COMPLET	one) 2 MEDI	CAL EXAMINE	R: On the beels of a	xamination and/	or investigation	n, in my o	olnion, d	leath occur	red at the t	ime, data and ple	ica, and d	dua to the	cause(s)) and manner se stated.
BE C	29b. SIGNATURE AND TITLE	OF CENTIFIER	1						NSE NUM		2			(Month, Day, Year)
10		N						D	430	91		> :	5-11	1-95
	30. NAME AND ADDRESS OF	LL 1	HOUSE	AVE.	7	FRB.	DEK	2101	4	M.	0 0	217	70/	,
	31. DATE FILED (Month, Day, MAY 1	2 1995	32. REGISTRA	S SIGNATURE	Pertell	E								

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

RUCH BVelyn Boyles 1.0004. MCCUNTY NAMERY		1 - STATE REGISTRAR		CERTII	FICATE OF	DEATH	REG. NO).	
# A SOCIAL SECURITY NUMBERS # 15 SEX 1.5 SEX									
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PROBLEM NAME (IT OR MIRROR) Frederick Memorial Hospital Frederick Memorial Hospital Frederick F				26			7. DATE OF BIRTH Feb. 18,1	.909	BIRTHPLACE (State or Foreign Country) MIChigan
DE STREET AND NAMERON 120 KLine Blvd 120 KLine Blvd 120 Minus Stratus 120 Meritad 120 Merit	ror	Frederick Memoria		a1	96. CITY, TOWN Frede	on Location of D		9c. COUNTY	OF DEATN
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SINUTISOURS LICENSED SINUTISOURS LICENSED	2	Charles M. Boyles							
22. MAME AND ADDRESS OF FACALITY KECNEY and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701 23. PART I. Enter the diseasea, or complications that ceused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, interval Between Jones and Death of Control Between Jones and Death of		20e. METNOD OF DISPOSITION 1 Burlel 2 Cremston 3 Remove 4 Donetton 5 Other (Specify)	I from State				1		
NOUTO 106 East Church St., Frederick, Md. 21701 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inherent Between abock, or heart feliure. List only one cabes on each line.		21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME A	ND ADDRESS OF FA			
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):		+ Kicharo E.	Draf	MOO255					
MMEDIATE CAUSE (Final deates or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR	ŀ	23. PART i. Enter the diseasea, or cor ahock, or heert feilure. Lis	nplicetions that cerest only one cause of	used the death. Do	not enter the m	de of dying, suc	h as cardiac or reap	Iratory arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DIE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS		disease or condition	Acute	dyeli	blast	è leul	Senuc	Crisc	Onset and Death
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PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1	CATIO	if any, leading to immediate cause. Enter UNDERLYING	DE TO (OR	AS A CONSEQUENCE) Г]:				
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. PLACE OF DEATH YES NO UNCERTAIN 25. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	EDICA	Aut	Hardy	o philit	us (V	Jue .	PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Accident 3 Suicide 6 Could not be determined 29e. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. Could not be determined 29e. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated.	Σ. Σ	DID TOBACCO USE CONTRIE	BUTE TO CAUSI	OF DEATH Y	ES NO [UNCERTAIN	v 🗆		1 VES 2 NO
Accident 3 Suicide 6 Could not be determined 29e. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. Could not be determined 29e. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated.	S	EXAMINER?							
Accident 3 Suicide 6 Could not be determined 29e. CERTIFFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner es stated. 29b. SIGNATURE AND TITLE O CHITISH 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) 29d. DATE SIONED (Month, Day, Year)	₹ I				4 - Nursing Nor				
3 Suicide 4 Nomicide 5 Could not be determined 299. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. 299. SIGNATURE AND TITLE O DATE SIONED (Month, Day, Year) 290. LICENSE NUMBER 290. LICENSE NUMBER 290. DATE SIONED (Month, Day, Year)		1 Netural 5 Pending			JURY W	PRK?	28d. DESCRIBE HOW !	NJURY OCCUR	ED
296. SIGNATURE AND TITLE O CONTINUE 296. LICENSE NUMBER D 071.86		3 Suicide 6 Could not be	28e. PLACE OF INJ building, etc. (URY — At home, ferm, (Specify)	atreet, fectory, offic	•	281. LOCATION (Street of City or Town, Stete)	and Number or I	Rural Route Number,
296. SIGNATURE AND TITLE O CONTINUE 296. LICENSE NUMBER D 071.86	OMPLE	(Check only							euse(e) end manner ee stated.
D 07186 > 518 95				A					
30. NAME AND WIDNESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		Ko lle	win	Metho				> 5	18 95
Dr. Phillip Shapiro MD 814 Toll House Ave., Frederick, Maryland 21701				4		. Freder	ick, Marvl	and 21	701
31. DATE FILED (Month, Day, Year) MAY 1 0 1995 Julia distribution Review		31. DATE FILED (Month, Day, Year)	32. REGISTRASIS	SIGNATURE PARTIES OF THE PARTIES OF		-			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 means after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medicini azaminer must be notified at once.
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	FOR 1 - STATE	STATE OF	MARYLAND /	DEPAF	RTMENT	OF H	EALTH	AND I	MENTAL I	HYGIEN	E		
	REGISTRAR		CE	RIII	ICATE	OF	DEA	ГН		REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DEATH	NY .	YEAR 3.	TIME OF DEATH
			1. Blouir						May	7, 1	995		:27 am M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER		IF UNDER		7. DATE OF	BIRTH		8. BIRTHPL/ Country)	ACE (State or Foreign
	015-01-7825	1 M 2 XF	83	YRS.	MONTHS	DAYS	HOURS	MIN.	Febre	191	2		chusetts
	9e. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY,	TOWN 0	R LOCATION	ON OF DE		17.		TY OF DEAT	Administration of the Control of the
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15						Ga.	ithe	rsbu.	rg			lontgo	mery
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	Maryland Me	ontgomery	7				Ве	ethe	sda			1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101.	. ZIP CODE		Buu		10g. CITIZ		T COUNTRY?
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25	11. MARITAL STATUS		IT EVER IN U.S. ARM	IED	13. V	MS DEC			IC ORIGIN? (Enacify Yes			States American Indian
	1 Never Married 2 Merried		YES 2 NO		11	yes, spe	ecity Cuba	n, Mexica	n, Puerto Rici	m, atc.)	Or NO.		American Indian, hite, atc.
B	3XXWidowed 4 Divorced	IF YES, GIVE Y	WH OH DATES		١,	☐ YES	s □Xino	Specify	<i>/</i> ·		- 1	Specify:	57h 2 1 a
0	15. DECEDENT'S EQU		16a, DEC	EDENT'S	USUAL OC	CUPATIO	N.		16h KI	ND OF BUI	INESS/INDI	ICTDV	White
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			Bleu				18. MOTE	HER'S NAI	ME (First, Mide	fle, Maiden	Sumeme)		
H		Euclide I								е Ма			
2	19s. INFORMANT'S NAME (Type/Print)		19b.	MAILING	AOORESS	(Street at	nd Number	or Rural F	Route Number,	City or Tow	n, State, Zip	Code)	
	Dorothy Blo	iin	48	57 I	Batte	ry 1	Lane	#40]	l Beth	esda	, Mar	yland	20814
	20e. METHOD OF DISPOSITION 1 Burlel 2XXCremation 3 Rem	ovel from State	20b. PLACE A	ND DATE	OF DISPOSI	TION (Na	me of		OATE	20c. LO	CATION C	Ity or Town,	State
	4 Donation 6 Other (Specify)	Oval from State	cemetery, crem	one o	ther place) rv. Cr	May	y 8 tori:	,199	95 nc.	Be	thesd	a. Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	//		22. N	AME AN	D ADDRES	SS OF FAC	CILITY	Func	ral II	omo /	1,14114
	19	SV 11	1		Be	the	sda-(Chevi	v Chas	e. I	nc. 7	557 W	isconsin
_	no part Francis	Seplen	MOO	1335	Δ 37	00114	a Rat	haer	da Ma	rizz] a	nd 20	01/1-2	501
	23. PART I. Enter the diseases, or of ahock, or heart fallure.	complisations the List only one cau	causad the dea	th. Do r	not entar i	tha mod	de of dyl	ng, such	h aa cardiac	or reapi	ratory arre	eat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final				,								Onset and Death
	disease or condition resulting in death)	· HX E	Over	6)	a hi	OV	1						
		DUE TO	(OR AS A CONSEQU	JENCE O	F):		1						
z		((K)	2016		CLY	YE	54	-					
9	Sequentially list conditions, If any, leading to immediate	DUE TO	(OR AS A CONSEQU	JENCE OF	F):		127						
ΙĀ	cause. Enter UNDERLYING												
Ĕ	CAUSE (Disease or Injury that Initiated events	DUE TO	(OR AS A CONSEQU	JENCE OF	F):								-
ERTIFICATION	resulting in death) LAST	20											
빙		a											
-	PART II. Other algnificent condition	s contributing to	death but not re-	suiting (n the und	derlying	cause g	iven in i	Part i. 24	a. WAS AN			RE AUTOPSY FINDINGS
· 5										PERFOR			MILABLE PRIOR TO MPLETION OF CAUSE
									- '	YES 2	XΙΝΟ		DEATH?
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PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	KIBUTE TO CA				-	UNC	ERTAIN	1 🗆				
ō	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	OF DEAT	OTHER								
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표	27. MANNER OF OEATH	28a. DATE OF (Month, D		28b. TIM	E OF	28c. INJU			28d. DESCR	BE HOW I	JURY OCC	UREO	
BY	1 X Netural 5 Pending 2 Accident Investigation	41337			M		ES 2 [NO					
0	3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At hom	e, ferm, s	treet, facto	ry, office	,		28f. LOCATIO	ON (Street a	nd Number o	or Runti Route	Number,
u l	4 Homicide datermined	bullanig,	etc. (Specify)						City or T	own, Stete)			
COMPLET	29e. CERTIFIER 1 [X] CERTIFYING PHYSIC	CIAN: To the to the	- transfer	h a	al are				2	I water	0.00		
₽	(Check only												
8	2 MEDICAL EXAMINE		sammation end/or in	vestigatio	n, in my op	inion, de	eth occur	ed at the t	time, data and	l place, en	due to the	cause(a) en	d manner as stated.
<u> </u>	29b. SIGNATURE AND TITLE OF CERTIFIER	0.0.0	7 / 1	. ^			29c. LICE	NSE NUM	BER		29d, DATE	SIGNED (Mo	rith, Day, Year)

D. 19261 Montgomery Village Avenue G-10 Gaithersburg, Maryland
32. 960|STRAK'S SIGNATURE

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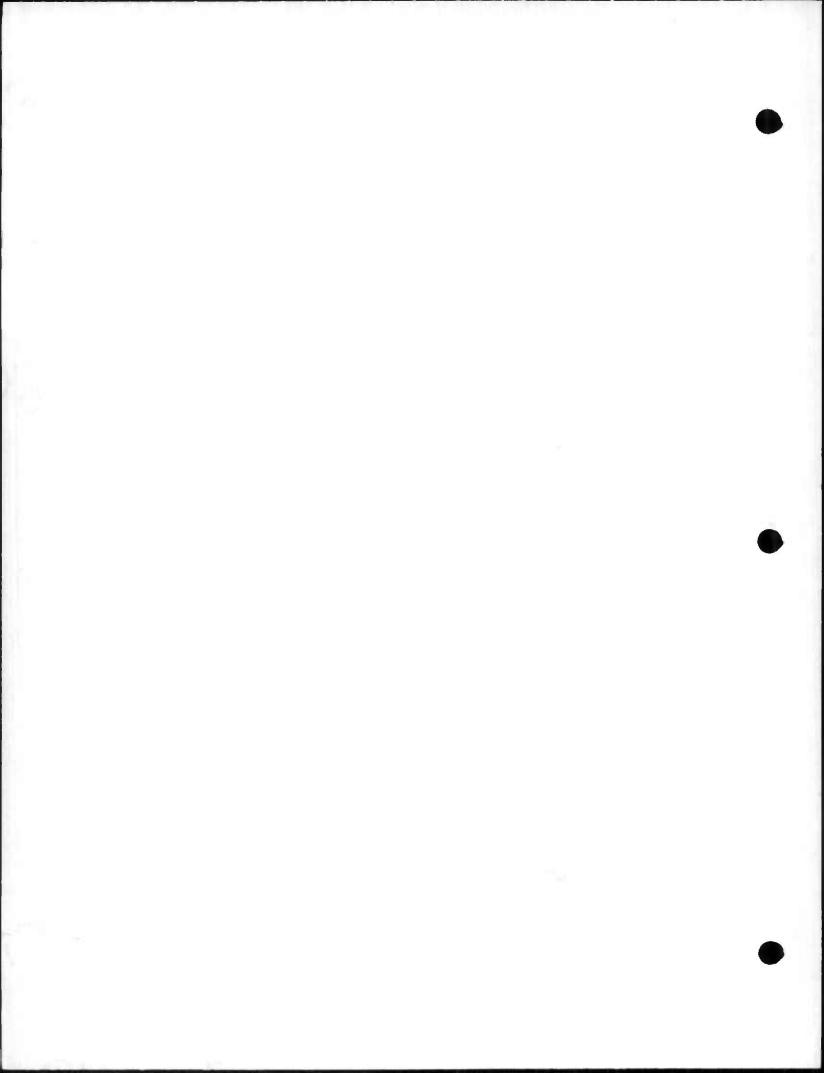
May 8, 1995

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	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
1	1. DECEDENT'S NAME (First, Middle, Last)	BACH	- HANCE			2. DATE OF DEATH	81 1980	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5. S			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	s. BIRTI	HPLACE (State or Foreign			
	218-56-9731	YRS.	ONTHS DAYS	HOURS MIN.	Dec. 7, 19	Count	Denmark				
	9a. FACILITY NAME (If not institution, give street a		1	b. CITY, TOWN C	R LOCATION OF D		9c. COUNTY OF D				
DIRECTOR	Suburban Hospital			Bet	hesda		Montgo	omery			
Di C	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY			
DIR	Maryland Montgomery			Garrett Park							
ME	10e. STREET AND NUMBER		101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	10902 Kenilworth		20896			United S					
5		WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF NISPA	NIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.)	or No- 14. RAC	E — American Indien, k, White, etc.			
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2 NO Specif		Spec				
	15. DECEDENT'S EDUCATIO	IN.	18a. DECEDENT'S US	UAL OCCUPATION	N	16b. KIND OF BUI	SINESS/INDUSTRY	WILLE			
ET	(Specify only highest grade comp	flege (1-4 or 5+)		k done during mo:		100.7070	SINE SSINE SSINE				
MPL		Painting	Contra	ctor	Pair	nting					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Maiden	Surname)				
BE	Einer Hansen				Anna I	Bach		and the second section			
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow					
	Corry G.P. Bach-Han					,Garrett I		20896			
	1 - Buriel 2 K Cremation 3 - Removat i	rom Stata ceme	PLACE AND DATE OF stery, crematory or othe	r place) Mav	5, 1995		CATION — City or To				
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	Montgomery Crematorium, Inc. Betnesda, Maryland									
	10111	/	M00100	Rober	t A. Pur hesda-Ch	nphrey Fune	eral Home	/			
_	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501										
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart feliure. List only one cause on each line. Approximate interval Between										
		FCUTE RE									
	DUE TO (OR AS A CONSEQUENCE OF): 8 YSTEMIC INFLAMMATORY RESPONSE SYNDROME CURRENT Sequentially list conditions,										
ON I	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
₽.	cause. Enter UNDERLYING										
Ē	thet initieted events	DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST										
AL C	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
	PNEUMONECTOMY. PNEUMONIA: ATRIAL FIRRILLATION, PERFORMED? MAILBERTION OF TOO COMPLETION OF THE TOO CONTINUE TION OF THE TOO CONTINUE TION OF THE TOO CONTINUE TO C										
MEDIC	PHOLECTOTIC MEPATY S THROMESOCYTORENIA. RODNE HOCCOM										
2 2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH								
SIC	A CT AMP A AND A	SPITAL: Inpatient 2 - ER/Outpa		THER: Nursing Home	5 🗆 Rasidenca	6 Other (Specify)					
PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME (IRY AT	28d. DESCRIBE NOW I	NJURY OCCURED				
BY	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO						
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	— At home, farm, stre	et, factory, office		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
PLE	290. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my knowle	dge, death occurred	nt the time, date	and place, and due	to the cause(a) and man	ner ea stated.				
MO	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
ш	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
TO B	Mundas, 11	71 (10)	· 5/2	195							
F	30. NAME AND ADDRESS OF PERSON WHO CON	MD 49		RAY A	LVE B	ETHELDA,	MD 2	0814			
i	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGNA	TURE				. ,	//			
	MAY 08 1995	alia Student	Carball								





DIRECTOR: After the hours after death v

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31. DATE FILED (Month, Day, Year)

MAY 05 1995

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	JOR: After this certificate has been signed by the attending physician and completely filled in by the fit after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	mari
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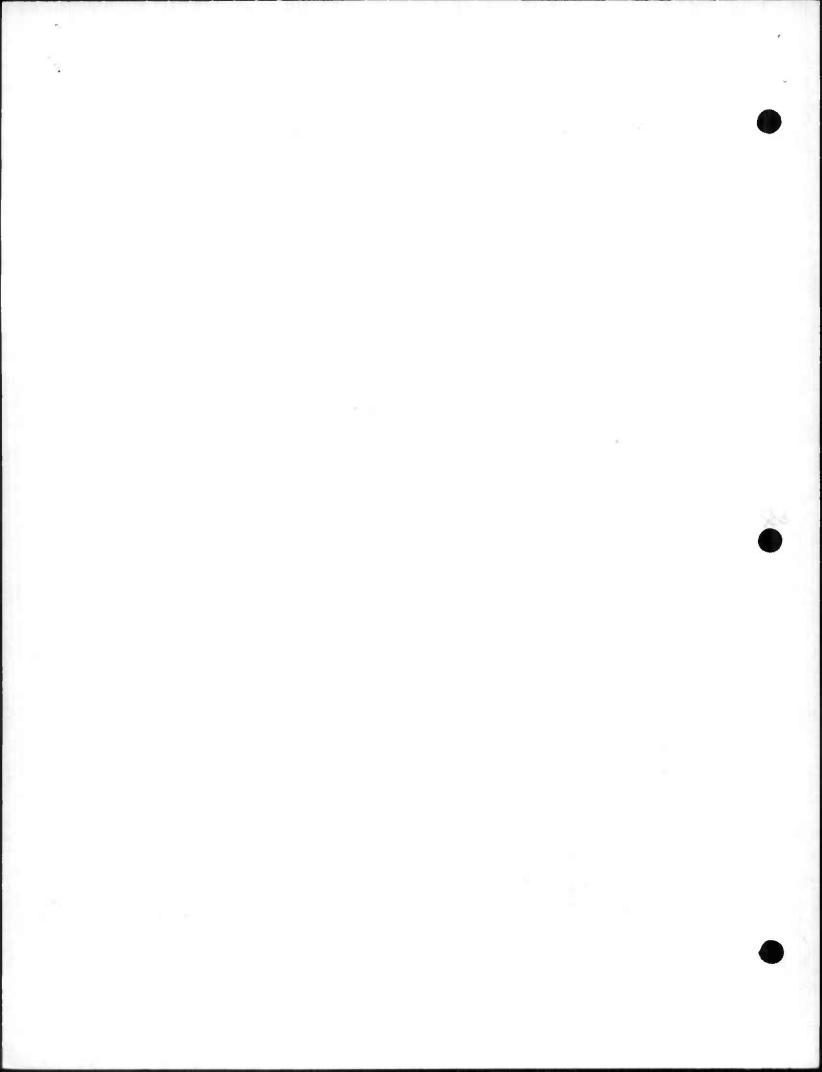
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REGUNO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR JUSEPH 830 0 :51 BH Harry agr. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 932 DAYS HOURS 161 26 2770 1 XM 2 F MIN. 62 YRS. October PENNA. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MONTGOMERY MD. SILVER SPRING 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8709 PLYMOUTH ST. #1 20901 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
 I YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Merried Specify: WHITE BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5 +) MANAGER HOTEL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) FRANK BACHINSKI MARY BE VASS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 15th ST. N.W. WASHINGTON, D.C. 20012 EUGENE BACHINSKI 6615 20e. METHOD OF DISPOSITION
1 🔀 Burlal 2 🗆 Cremetion 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE MARYS CEMETERY 4 Donation 5 Other (Specify) MAY20,1995 NORTHFIELD ,MASS. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME 254 CARROLL ST NW WASHINGTON, D.C. 20012 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Lasta Gostos Pheading resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 246. WERE AUTOPSY FINDINGS PERFORMED? AMAIL ABLE PRIOR TO alcoholien chronic COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) TES 2 NO 1 | Inpatient 2 ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural
Acciden 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, term, street, tactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(a) and manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE E . D0854 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8218 WISCUSIN

32. REGISTRAR'S SIGNATIONE FULL O'AUGUST RANGELL

Mo

Acre



DIVISION OF VITAL RECORDS, P.O. BOX 68760

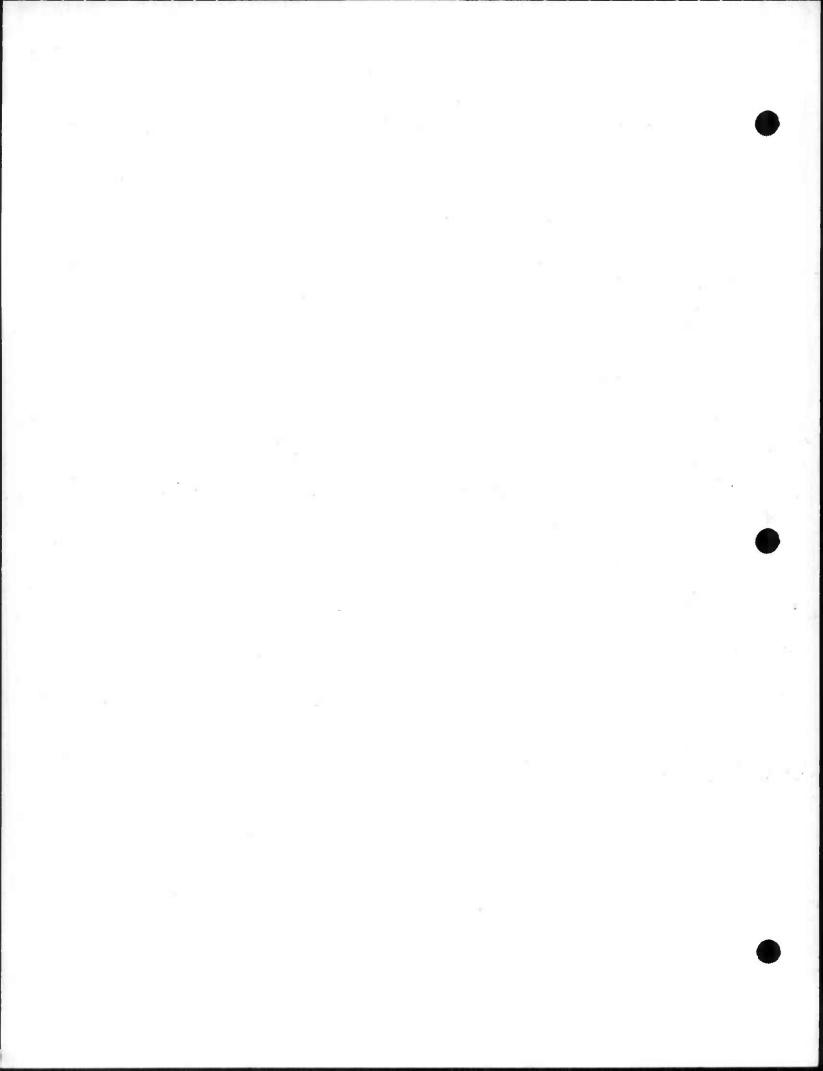
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 50 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely-filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

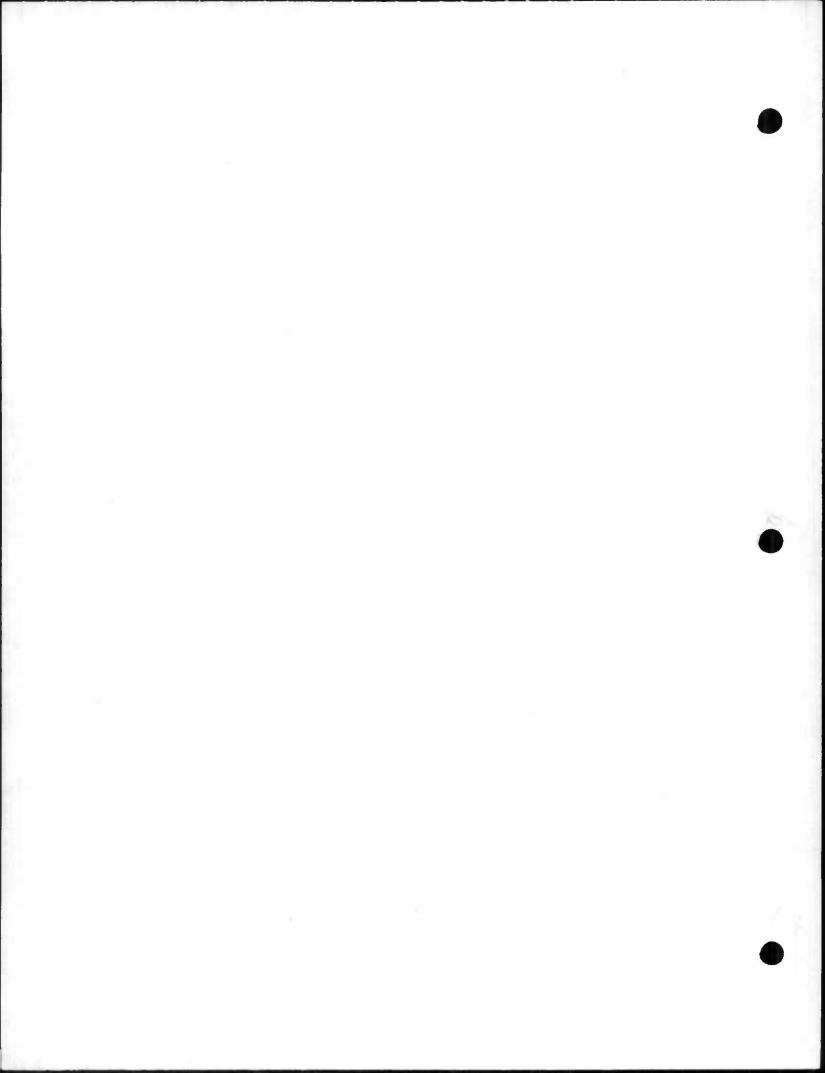
FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.
ECEDENT'S NAME (First, Middle, Last)	20.410	2. DATE OF DEATH

	1 - STATE REGISTRAR SIAIE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
1. OECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH										3. TIME OF DEATH			
	LLOYD W	BRAVO					MONTH DAY YEAR 1995			1010 04			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) III			IF UNDER	IF UNDER 1 YEAR					A. BIRTH	IPLACE (State or Foreign	
	219-92-2094	1½ M 2 □ F 53		YRS.	MONTHS DAYS		HOURS	MIN.		, Day, Year)		Countr	w) maica
	9e. FACILITY NAME (If not institution, give stre	et and number)			9b, CITY	, TOWN O	R LOCATIO			- /	9c. COUNTY OF DEATH		
DIRECTOR	Shady Grove Adventist Hospital Rockville Montgom									omery			
<u> </u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d									10d. INSIDE CITY			
뜽	Maryland Mo	7		Pool							-	LIMITS?	
	10e. STREET AND NUMBER								10a, CIT	IZEN OF V	VHAT COUNTRY?		
FUNERAL	19824 Westerly Ave		20837			7					tates		
5		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Sp.				? (Specify Yes	or No-	14. RACE	— American Indian,
ВУ	1 Never Married 2 X Merried 3 Widowed 4 Divorced	IF YES, GIVE WA	WAR OR OATES 1 YE			YES	specify Cuben, Mexican, Puerto Rican, etc.) ES 2 NO Specify:			ican, atc.)	Specify:		
ED	15. DECEDENT'S EQUAL	TION	16e. DEC	CEDENT'S	USUAL O	CCUPATIO	N		16b.	KIND OF BUS	SINESS/INC	DUSTRY	Black
Li,	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	- Side	ve kind of a Do NOT us	work done one retired.)	during mos	it of workin	9					
COMPLET	12			ity	Insu	ranc	e En	gine	er	Electi	conic	s	
00	17. FATNER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, N	liddle, Meiden	Sumama)		
BE	Kenneth Brave)						Bery	l Mo	ngal			
2	19a. INFORMANT'S NAME (Type/Print)									er, City or Tow			
	Maucha Bravo									lesvi			
	20a. METNOD OF DISPOSITION 1 A Burlel 2 Cremellon 3 Remov	ral from Stale	cometery crem Gate	natory or o	OF DISPOS ther place)	ITION (Nar	ne of Ma	у 6,	1995	20c. LO	CATION —		
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGHT	NSEE .	Gate c	or He					MI ITY D				g,Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENTER 12. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funer Home/Rockville, Inc., 300 W. Montgomery A Rockville, Maryland 20850-2805									tgomery Ave			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	IMMEDIATE CAUSE (Final							Interval Between Onset and Death					
	disease or condition resulting in death) a. Carrier Cerres									1 40			
	DUE TO (OR AS A CONSEQUENCE OF):												
8	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Communa Culture Australia									104			
¥										100			
[윤]	CAUSE (Disease or Injury that Initiated events	DUE TO (C	OR AS A CONSED	UENCE OF	F):	dise	nge						1 7
CERTIFICATION	resulting in death) LAST												
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
JICAL	. Street augministrative continuously to death but not residing in					n the underlying cause given in Par			Part I.	PERFORMED?		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
								OF DEATH?					
: MED										1 TES 2 NO			
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)												
PHYSICIAN:	EXAMINER?	HOSFITAL:			OTHER	1:							
H	1 ☐ YES 2 ☑ YNO 1 ☐ Monpetlent 2 ☐ ER/Outpetlent 3 ☐ DOA 27. MANNER OF DEATH 26b. TIME 26b. TIME					□ Nursing Home 5 □ Residence 6 □ Othe ○ OF 26c, INJURY AT 26d, DES				ther (Specify) DESCRIBE NOW INJURY OCCURED			
	1 Natural 5 Pending	(Month, Day	Year)	INJ	URY M	WOR	RK7 ES 2	NO					
ЭВУ	2 Accident Investigation 3 Suicide 6 Could not be	INJURY — At hon	ne, farm, s	dreet, fecti				26f. LOCATION (Street and Number or Rural Route Nu			loute Number,		
Ē	4 Nomicide building, etc. (Specify)												
2	29e. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of m	ty knowledge, des	th occum	d at the ti	me, date e	and place	and due	to the caus	e(e) and man	Cost on what	ad	
COMPLETED		One)											
w	296. SIGNATORE AND TITLE OF CERTIFIER						29c. LICE	NSE NUM				E SIGNED	(Month, Day, Year)
TO B	Kt rundom MO						24	9 -	71 Mm 4			+ 1591	
Dennis/Friedman.									M.D.				
	ILLUS SITA	DY UROI	15 Kd		K	SCK	UIL	t	1-1)			
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE										
	MAY 08 1995	Juli As	P	-									
	- (/	WOOD	-									DNMH-16 Rev 1/89



		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	IEALTH AND		HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF		YEAR	3. TIME OF OEATH	
		EARL	AUGUSTUS	BO		MAY03,19			15:15 PM		
		4. SOCIAL SECURITY NUMBER		MC	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D		8. BIR	THPLACE (State or Foreign	
P		577-09-5808	1 M 2 F 79	YRS.			APRII.	10.191		ryland	
3 should	Œ	9a. FACILITY NAME (If not institution, give s		91	b. CITY, TOWN C	OR LOCATION OF DE	EATH	9c.	COUNTY OF	DÉATH	
1, 2,	16	SUBURBAN HOSPITAL Bethesda MONTGOMERY RESIDENCE OF DECEDENT									
Pages	HE I	10e. STATE 10b. COUNT		10c. CITY, T	OWN OR LOCAT	TION				10d. INSIDE CITY LIMITS?	
permit.	0	Maryland Mo	ntgomery	K€	ensingt		·			1 X YES 2 NO	
ar per	RAL				101	. ZIP CODE		t0g.	CITIZEN OF	WHAT COUNTRY?	
020 physician. burlal-transit	FUNE	2700 McComas Aven	12. WAS DECEDENT EVER IN U	IS ARMED	1 12 MMS DEC	208 ENDENT OF HISPAN		Danalda Maria a Ma		5.A.	
020 physician. burial-trar		t Never Married 2 Married	FORCES? t XYES IF YES, GIVE WAR OR DATE	2 NO	If yes, sp	ecity Cuban, Mexica 2 😿 NO Specify	n, Puerto Rica		Bla	CE — American Indian, ick, White, atc.	
9 8 8	ВУ	3 Widowed 4 Divorced	WW II		1 1 123	Z K NO Specin	<i>y</i> :			www. √hite	
Se affe S	ED	15. DECEDENT'S EDU (Specify only highest grade	CATION t	6a. DECEDENT'S US	UAL OCCUPATIO	ON st of working	16b. Kil	ND OF BUSINESS		MICC	
10 EE OF TO	E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	itired.)	or or working					
AND 21 he hospital or detached for u	COMPL		2	Banker				Banking			
⋖ 2 2 5		17. FATHER'S NAME (First, Middle, Last)				E-0.0	ME (First, Middle, Meiden Surname)				
	Ⅱ	Joseph Guida Bow 190. INFORMANT'S NAME (Type/Print)	man				1 Lee				
5 5 5 5	임					nd Number or Rural I					
1 2 8 2 E		Annie Louise Bow		12/00 MC		Avenue K					
Page 6 may al director, pa		1 X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State cemete	ery, crematory or other	place)		DATE	20c. LOCATION	-		
LTIMOR ath. Page 6 ma neral director, p		21. SIGNATURE OF FUNERAL SERVICE LIC		dar Hill		TY 5/	81/95 CILITY	Suitlar	nd Mai	yland	
ALTIN death. Pag tuneral di tuneral di c.								Funeral Home, Inc.			
rs after de n by the fur removal.	\vdash	23. PART I. Enter the diseases, or o	ricole	ti dina mini	500 U	niversit	y Blvd	.,W. Si	L1.Spi	.,MD 20901	
		shock, or heart failure.	List only one cause on aec	ne death. Do not h line.	enter the mo	de of dying, auci	h as cerdiac	or reapiratory	y errest,	Approximate interval Between	
Pe on		IMMEDIATE CAUSE (Final disease or condition	CHARLIA	1.0.1	D at	11-10		-4 FF (~+	-	Onset and Daeth	
ted within 24 completely fill, cremation, tal, cremation, the		resulting in death)	BUNSHOT DUE TO (OR AS A C	ONSEQUENCE OF	D OF	HOAD	100	MIAC			
B 5 - 6	_						,				
	흔	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A C	ONSEQUENCE OF):							
ate be prior tra	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	с								
ertifica ing phy giene	E	that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):							
T E BE	CERTIFICATION	resulting in death) LAST	d								
9 4 3	AL C	PART II. Other aignificant condition	s contributing to death but	not resulting in t	ha underlylno	ceuse given in	Part I. 24	. WAS AN AUTO	PSY 24	b. WERE AUTOPSY FINDINGS	
- 28 - 7		PERFORMED?							AVAILABLE PRIOR TO COMPLETION OF CAUSE		
requires that een signed by of Health an	MEDIC						_ '	YES 2 - NO	'	OF DEATH?	
w requebeen been of of of	2	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES	П NO П	UNCERTAIN	<u> </u>			THES 2 NO	
The law te has be ate Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26	PLACE OF OEATH (
SICIAN: The certificate the State	Sic	XXxE2 5 □ NO	HOSPITAL: t ☐ inpatient 2 X ER/Outpeti		THER: Nursing Home	e 6 🗆 Residence	6 Other (S)	pecify)	_		
PHYSICIA this certifi with the	H	27. MANNER OF GEATH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME O		URY AT RK?	28d. OEŞCRI	BE HOW INJURY	OCCUREO		
OING Pt After th death w	ВУ	t Natural 5 Pending 2 Accident Investigation	5-3-95	1400		ES 2 NO	SUBJE	CT SH	ST SE	J.F	
OR ATTENDING PHYSICIAN. The law requires the DIRECTOR: After this certificate has been signed I hours after death with the State Dept. of Health as Item 28 is marked, or item 23 shows any	ED	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY — building, etc. (Specify	J.	it, tactory, office		City or To	wn, State)		Route Number, MD	
OR ATT DIRECTE hours at	ш			HOME			2700 M	c coma	SAVE	KENSINGTON	
TAL OR /	COMPL		CIAN: To the best of my knowled								
HOSPITAL FUNERAL WITHIN 72	Į Š	↑ MEDICAL EXAMINE	R: On the basis of esimination a	nd/or investigation, is	n my opinion, de	eath occured at the	time, date and	place, and dua	to the cause	(a) and menner as stated.	
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE (100 SIGNATURE AND TITLE OF CENTIFIES	allh	1		29c. LICENSE NUN	IBER	29d.	DATE SIGNE	D (Month, Day, Year)	
5 5 3 X	TO B	July 1	de Control	V		OCME		>	MAY (04,1995	
	- 1	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DEAT								
\		MARKO F. GOD	W JR M/		n Str	eet, Ba	ltimo	ore, M	aryla	and 21201	
L		31. DATE FILEO (Month, Day, Year)	32 AGGISTRAB'S SIGNAT	Revolath							

DHMH-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an float of least. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	HEGISTRAH				EHILL	CALE	OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First	Middle, Lest)							2. DATE O	F DEATH	v	YEAR	3. TIME OF OEATH	
		RMAN		BROV					MAY	6		95	11:55 P"	
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.		IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	BIRTN Day, Year)		9. BIRTI Count	PLACE (State or Foreign	
V	577-36-89		1 🔀 M 2 🗆 F	88	YRS.		541.5	min.	APR.9,1907				ASH. D.C.	
~	Se. FACILITY NAME (If not in	stitution, give st	treet end number)			9b. CITY, TOWN OR LOCATION OF DEATN						9c. COUNTY OF DEATH		
DIRECTOR	HEBRE		E			ROCKVILLE MONTGO							OMERY	
ត្ត	RESIDENCE OF DEC	10b. COUNTY	,		Inc. CITY									
<u>E</u>	MD.		TGOMERY								10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	MON	IGOMERY			ROCK					1 XYES 2 NO			
FUNERAL		MONTHID	OCE DD				101.	ZIP CODE			10g. CIT		WHAT COUNTRY?	
۳	11. MARITAL STATUS	MONTR	OSE RD.					2085					S.A.	
립	1 Never Married 2	Merried	12. WAS DECEDEN FORCES? 1	YES 2	NO NO	14	yes, spe	ENDENT OF HISPAI	in, Puerto Ric	(Specify Yes an, etc.)	or No—	14. RACI Blac	E — Americen Indien, k, White, atc.	
'n	3 Widowed 4 Divo		IF YES, GIVE W			11	_ YES	2 NO Specif	y:			Spec	WHITE	
	15. DEC	EDENT'S EDUC	CATION		DECEDENT'S	ISUAL OCC	CUPATIO	N .	16b K	IND OF BUS	INFEC/IN	DUSTRY	MIITIE	
	(Specify online Elementary/Secondary (0	highest grade	College (1-4 or 5 +		(Give kind of wife, Do NOT use	ork done du retired.)	ring mos	st of working				0001111		
립	10			<i>'</i>	NURS	RSES ASSISTANT F						GOV	1 m	
COMPLETED	17. FATHER'S NAME (First, M	iddle, Last)				20		18. MOTHER'S NA	ME (First, Mic			GOV	1.	
BEC	BENJA	MIN	BROW	DY				CE	CILI	Δ	C	ACH	g	
						ADDRESS (Street or	nd Number or Rural					0	
임	BEULAH I	BROWD	Y										D. 20782	
	200. METHOD OF DISPOSIT				EANDDATEO	FDISPOSIT	ION (Ner	me of	DATE			City or To		
	1 Donation 6 Other	majory or other place) MBERS CREMATORY 5/9 RIVERDALE							LE MD					
ij	21. SIGNATURE OF FUNERA		22. NAME AND ADDRESS OF FACILITY											
Marchanter Chamber													20737	
	23. PART I. Enter the di	-41	unua		0091	W.	W.	CHAMB	ERS (co.,	RIV	ERD	ALE, MD.	
	shock, or he	eart fellure. I	List only one cau	se on each li	ne.	ot enter ti	ne mod	e or dying, auc	h as cardia	c or reepi	ratory ar	rest,	Approximate Interval Between	
ł	IMMEDIATE CAUSE (Findisease or condition	nl .		10	D 1:								Onset and Death	
	resulting in death)	→ ,		(OR AS A CONS	MAL	John	113							
			DUE TO	(OR AS A CONS	EQUENCE OF	:								
8	Sequentially list conditi		DUE TO	OR AS A CONS	FOURNCE OF									
Ā	If any, leading to immed cause. Enter UNDERLY!	NG				•								
CERTIFICATION	CAUSE (Disease or Inju	ny 🔰 °	DUE TO	OR AS A CONS	EQUENCE OF	QUENCE OF:								
분	resulting in death) LAS	T												
შ														
EDICAL	PART II. Other algolitica	nt condition	e contributing to	death but not	reaulting in	the und	erlying	ceuse given in	Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
움ㅣ	ATHERUSCIE	ROT	C C/F	1000	143 CU	LIM		DIGON	1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?	
											1		1 TES 2 NO	
z I	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DE	ATH YES	S □ N	0 🗆	UNCERTAIN	V Z					
5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL/	CE OF DEATH									
PHYSICIAN: M	1 TES 2 NO		1 Inpetient 2	ER/Outpatient		OTHER:		5 Residence	6 Other (S	Specify)				
표	27. MANNER OF DEATH		28e. DATE OF (Month, De		28b. TIME		Bc. INJL WOF	JRY AT	28d. DESC	HBE NOW IN	JURY OC	CURED		
BY		Pending nvestigation				M		ES 2 NO						
	3 Suicide 6	Could not be	26e. PLACE Of building,	F INJURY — At P	nome, farm, st	reet, tector	y, office		28t. LOCAT	ON (Street e. Town, Stete)	nd Number	or Rural F	loute Number,	
EIE	4 Homicide	Setermined							J., J.	ionii, oidio,				
2	290. CERTIFIER 1 CERT	FYING PNYSIC	CIAN: To the best of	my knowledge, o	leath occurred	at the tim	e, date	end place, end due	to the ceuse	(e) end man	ner ee sta	led.		
COMPL) end menner as stated.	
Z I	29b. SIGNATURE AND TITE		0.0					29c. LICENSE NUM						
n	X	1 CUI	ullew	L						2	▶ A	1AL	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type I									
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

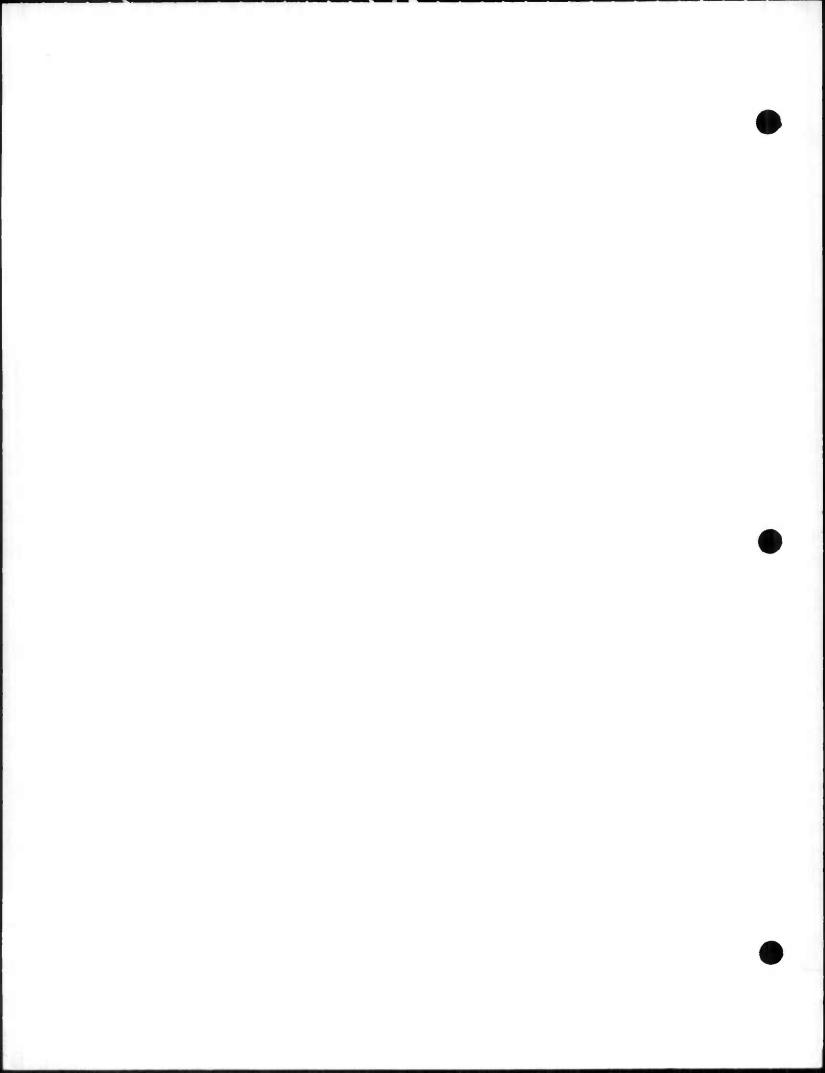
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTEND

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IENE
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	TER 5 NOV	-d Ho.	SUNS	B	~Ke	MONTH	YEAR OF	1 12 50 PM		
	4. SOCIAL SECURITY NUMBER		7	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Dey, Year)	1. B	IRTNPLACE (State or Foreign		
	1 1 2 1 30 7 1	1 JM 2 F	2 YRS. "	ONTHS DAYS	HOURS MIN.	ountry) nnsylvania				
	9e. FACILITY NAME (If not institution, give etr.	reet end number)	9	b. CITY, TOWN (R LOCATION OF DEA	Мау 14,192 тн	9c. COUNTY C			
DIRECTOR	Holy Cross Hospi	tal		Silver	Spring		Mont	gomery		
10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY		
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3AL	10e. STREET AND NUMBER			100	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
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	Bernard A. Burke					ve Barret	,			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO AI	DDRESS (Street e		ute Number, City or Town				
5	Joan M. Burke					aton, Mary				
	20e. METHOD OF DISPOSITION	20	DI ACE AND DATE OF	DISPOSITION /A/a	ma of	DATE 200 LOV	CATION CIN.	- Town State		
	1 XBuriet 2 Cremation 3 Remon	vat from State Cal	metery, cremetory or other	r place)	etery 5/1	0/05 811	or Cor	ing Manyland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.										
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DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DAT	E OF DEATH		YEAR	3. TIME OF DEATH	
	TEDDY	DOY	LE	BLANKENSHIP					MAY		1:43 PM				
	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs	s. last birthday)		ER 1 YEAR	-	R 24 HRS.	7. DATE	OF BIRTH	/		PLACE (State or Foreign	
	216-96-163	35	1 → M 2 □ F	28	YRS.	MONTHS	DAYS	HOURS	MIN.		R. 8,	1967	Country	ASH. D.C.	
OR	99. FACILITY NAME (If not in 4519 BUCH.	ANAN	STREET					OR LOCATE		EATH		9c. COU	PRINCE GEORGES		
5	RESIDENCE OF DEC	10b. COUNTY	,		T 400 OF	10c. CITY, TOWN OR LOCATION									
DIRECTOR	MD.		NCE GEORG	IRC	HYATTSVILLE							10d. INSIDE CIT LIMITS?			
7	10e. STREET AND NUMBER	2 4 144.2	TOD GEOIG					Of. ZIP COD				T 40 - 017		1 X YES 2 NO	
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BYF	1 Never Married 2		FORCES? 1 IF YES, GIVE V	YES 2 NO			If yes, specify Cuban, Mexican 1 YES 2 NO Specify.			en, Puerto	n, Puerto Rican, atc.)			White, atc.	
	3 Widowed 4 Divo										Specify	WHITE			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16a	(Give kind of	work don	e durina m	ION lost of worki	ing	16	b. KIND OF BU	SINESS/INI	DUSTRY		
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5	-)	Iffe. Do NOT use retired.) PLUMBER						P	LUMBI	INC		
O	17. FATHER'S NAME (First, M	iddle, Last)	-				70.07.06	16. MOT	HER'S NA	ME (First.	Middle, Melden		1110		
BE C	LARRY		BLANKENS	HIP				13000		VELLE		COLEN	MAN		
TO B	190. INFORMANT'S NAME (7)	vpe/Print)			19b. MAILING	ADDRE	SS (Street	end Number			iber, City or Tow				
F	LARRY E		4003	JE	FFER	SON S	ST.,	HYA'	ITSVIL	LE, N	D. 20	0781			
	20e. METHOD OF DISPOSITI	n 3 🗆 Remo	oval from State	20b. PLA	CE AND DATE	OF DISPO	OSITION (A	lame of		DAT			City or Tow		
	4 Donation 5 Other		- LARGE	COI	EMAN (EME	TERY			5/13		VANSA	NT,	VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY															
	MOOO91. W. W. CHAMBERS CO., RIVERDALE, MD. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,									D. 20737					
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition	line.			_				fratory ar	rest,	Approximata Interval Batween Onset and Death				
	resulting in death)	→	DUE TO	(OR AS A CON			MD	ma.	1	2001	PC)				
CERTIFICATION	Sequentially list conditi		DUE TO	(OR AS A COA	SEQUENCE OF):										
S	cause. Enter UNDERLYI CAUSE (Disease or Inju				NSEQUENCE OF):										
	that initiated evanta resulting in death) LAS		DUE TO	OR AS A CON											
8			l												
	PART II. Other algnifica	nt condition	contributing to	death but n	ot reculting	In the u	ınderiyir	ng cause	given in	Part I.	24s. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICAL											1 YES 2			COMPLETION OF CAUSE	
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PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		LACE OF DEA	OTHE)							
4×S	1 XYES 2 NO		1 □ Inpatient 2 □			4 🗆 Nu	ursing Hor	ne XX Re	sidence						
	1 Natural 5 I	Pending	Month D	ry. Year)	286. TIN	IURY	W	JURY AT ORK? YES 2	Van.	28d. DE	SCRIBE HOW I			25	
è l	2 Suloide	nvestigation	280. PLACE O	FINJURY - A		Outo			y no	28f. LOC	CATION (Street	3H(1	urta Number A A S	
回		Could not be letermined	building,	etc. (Specify)	Horm	1	,			4Clo	or Town, Stete) BUCH		T.O.	LINITING LI	
FE	29e. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge			time, date	e end place	, and due			1	ed.	TI /AIIVING	
COMPLET														end menner se stated.	
ш	206. SIGNATURE AND TITLE		1 0 10	A	1				ENSE NUI					Month, Day, Year)	
0	your	TO	Stell	77	N				C.M					0,1995	
٤	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	and the same of	4-11										
	MAKEST	CHOL	th JR	WD		n S	tre	et,	Bal	timo	ore, l	Mary	land	21201	
	31. DATE FILED (Month, Det.)	995	32. REGISTRA	R'S SIGNATUR	F. LL										
	MALTTI	כצב	Julia a man												

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

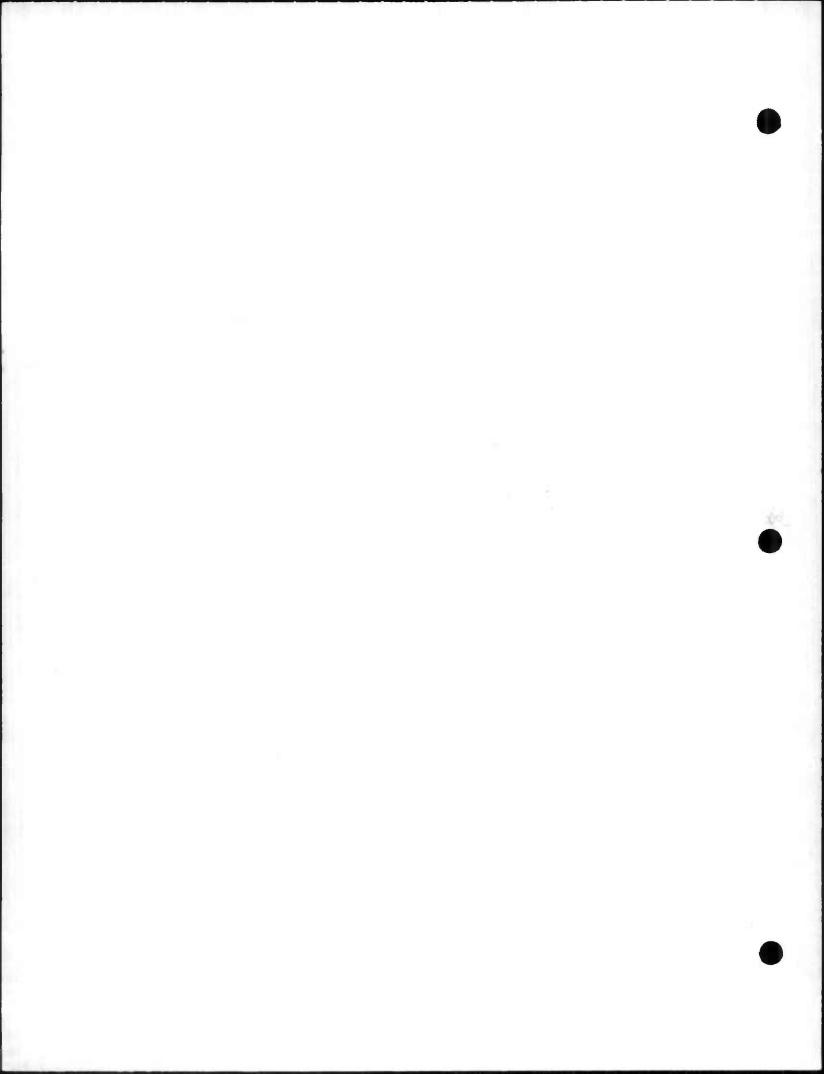
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

ļ	1. DECEDENT'S NAME (First	, Middle, Last)									OF DEATH	AW.	w=	3. TIME OF DEATH	
	Katheran				Berr	У				May		7	1995 0930 am		
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER	1 YEAR	-	R 24 HRS.	7. DATE	OF BIRTH I, Day, Year)			IPLACE (State or Foreign	
	561-54-742		1 ☐ M 2 🙀 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept	. 7,	1907	Course	PA	
~	9e. FACILITY NAME (If not in					9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF D						EATH		
5	Manor Manor		Bethesd	a		Chevy Chase Mo							Mont	ontgomery	
DIRECTOR	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN C	R LOCA	TION						10d, INSIDE CITY	
E	MD		Montgom	ery	Chevy Chase									LIMITS?	
AL	10e. STREET AND NUMBER				101. ZIP CODE							10g. CITIZEN OF WHAT COUNTRY?			
E	8700 Jo	nes Mi	11 Road								15		USA		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo			TEVER IN U.S. AR YES 2 XI WAR OR DATES							? (Specify Yellican, etc.)	ps or No— 14. RACE — American Indian, Black, White, etc. Specify: White			
		EDENT'S EDUC		16a. DE	CEDENT'S	USUAL O	CUPATI	ON .	-	16b.	KIND OF BU	SINESS/IN	DUSTRY		
COMPLETED		Elementary/Secondary (0-12) College (1-4 or 5 +)						IST OF WORK	ng						
MP				Homemaker							wn H	ome			
BE CO	17. FATHER'S NAME (First, M						Bail	Hiddle, Meiden .ey	Sumeme)						
2	19a. INFORMANT'S NAME (7										er, City or Tow	rn, State, Zi	p Code)		
	Mary Ellen			-			Lttsl		, PA	1523					
206. METHOD OF DISPOSITION 1 Duriel 2 Commention 3 Demoved from State Comments of Comment of Comments of Comment								+ C						wn, State VA	
- 1	21. SIGNATURE OF FUNERA	22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons													
5130 WI Ave. NW Washington, D. C. 20016									C. 20016						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Due to lorg as a considerance or								reat,	Approximate interval Between Onset and Death						
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											years			
	PART II. Other significa	nt condition	contributing to	deeth but not r	esulting i	n the un	derivin	Ceuse (given in	Part i.	24e. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS	
EDICAL	Valu	ul	zhea	J da		21	0				PERFOR	AMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	JBNO	ne	Lili	1 1						_	1 YES 2	E WO		OF DEATH?	
2	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF DEA	TH YE	SΠN	NO F	1 UNC	ERTAIN	ıΠ l				1 TES 2 NO	
Ž I	25. WAS CASE REFERRED TO				E OF DEAT			2 0110		, – 1					
Sic	EXAMINER?		HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DDA	OTHER		o 5 □ Re	sidence	8 🗆 Other	(Specify)				
Y PHYSICIAN:	The state of the s	Pending Investigation	28a. DATE OF (Month, D		28b. TIMI INJ	E OF	28c. INJ WC				CRIBE HOW I	NJURY OC	CURED		
LED BY	3 Suicide 8	Could not be determined	28e. PLACE O building,	F INJURY At ho etc. (Specify)	me, farm, s	treet, facto	ory, offic			281. LOCA City of	ATION (Street of Town, Stete)	and Numbe	r or Rural R	loute Number,	
COMPLETED			CIAN: To the best of												
႘၂			T. OII the been of e	Alministron eng/or i	investigatio	n, in my o	pinion, d	eath occur	red at the	time, date	end place, en	d due to ti	ne cause(e) end manner ee stated.	
TO BE	Kuss	eur 7	n. Til	ley 5		G.n		29c. LICE	(8	BER 8-8		•	e signed	(Month, Day, Year)	
	Dr. Russell	Tille	v 4701 M	assachus				N.W.,	Was	shing	ton.	D.C.	2001	6	
31. DATE FILED, MOOTY POR 1997 32. DEGISTRAR'S SIGNATURE MAY 11 1995 Julia Davidson Randall															



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SION OF VITAL RECORDS, P.O. BOX 68760	ENDING PHYSICIAN: The law requires that the death certificate be executed with
ISION OF VITAL RECORDS, P.O. BOX 68760	TTENDING PHYSICIAN: The law requires that the death certificate be executed with
VISION OF VITAL RECORDS, P.O. BOX 68760	ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
IVISION OF VITAL RECORDS, P.O. BOX 68760	R ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
DIVISION OF VITAL RECORDS, P.O. BOX 68760	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or attending physicial

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float head of the hospital or attending physician.

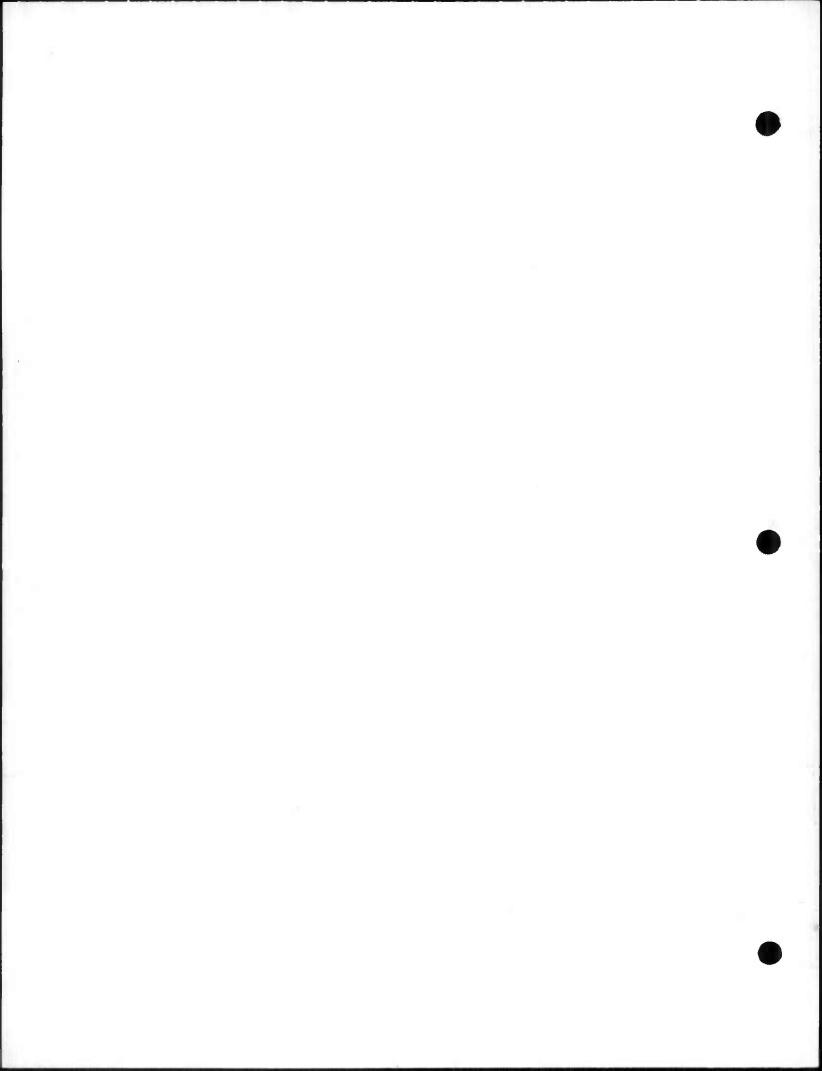
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAN		CERTIF	ICALE OF	DEATH	REG. N	0.			
	1. DECEDENT'S NAME (First, Middle, Last) JENNEISE	A. BREW	ER			2. DATE OF DEATH MONTH	DAY 1	3. TIME OF DEATH 4:15 am		
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER † YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH				
	466-46-3954	1 □ M 2 🂢 F	87 YRS.	MONTHS DAYS	HOURS MIN.	JULY 5,	.907	6. BIRTNPLACE (State or Foreign Country) TEXAS		
	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	INTY OF DEATN					
DIRECTOR	CARRIAGE HILL	- BETHESDA		BE'	THESDA		MO	NTGOMERY		
15	RESIDENCE OF DECEDENT									
#	10e. STATE 10b. COUNT	N /	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY		
5	N/A	NIA	WA	SHINGTO	N. D.C.			LIMITS?		
7	10e. STREET AND NUMBER		-		1. ZIP CODE		10a. CIT	10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	2518 TUNLAW ROAD	N.W.			20007		U.S			
3	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED			NIC ORIGIN? (Specify)				
	1 Never Married 2 Merried	FORCES? 1 YES	S 2 X NO	If yes, s	ecify Cuban, Mexico	en, Puerto Rican, etc.)	os or no—	14. RACE — American Indian, Black, White, etc.		
BY	3XXWidowed 4 □ Divorced	IF IES, GIVE WAR ON	DATES	1 YE	3 2 X NO Specif	ly:		Specify: WHITE		
9	15. DECEDENT'S EDI (Specify only highest grad	JCATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	16b, KIND OF B	USINESS/INC	DUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5+)										
AP I	12		ADMINIS	TRATIVE	ASSISTAN	NT FEDERA	L GOV	ERNMENT		
Ö										
	ROGER SMITH BUEALAH WILLIAMS									
	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)									
=	CHARLES A. DURKII	N	12524	RIDGECRI	EST PL. (GERMANTOWN	, MD	20874		
1 1	20e. METHOD OF DISPOSITION	20	D. PLACE AND DATE	OF DISPOSITION (N	ame of			City or Town, State		
1 Buriel 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) MT. COMFORT CREMATORY 5/11 ALEXANDRIA								RTA. VA.		
21. SIONATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY										
	JOSEPH GAWLER'S SONS, INC 20016									
\vdash	23. PART I. Exist the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	shock, or heert fallure.	List only one cause on	each line.	ot anter the mo	ae of dying, suc	th as cardiac or res	piratory an	reat, Approximata Interval Batween		
IMMEDIATE CAUSE (Final disease or condition										
	resulting in death)	· Duem						ZWKS		
		DUE TO (OR AS	A CONSEQUENCE OF	T):				2		
CERTIFICATION	Sequentially list conditions,	b. Kecurre	A CONSEQUENCE OF	motion				dyes		
F	if any, leeding to immediate cause. Enter UNDERLYING	DOE TO (OH AS	A CONSEQUENCE OF	·):						
윤	CAUSE (Disease or Injury that initiated events	C DUE TO (OR AS	A CONSEQUENCE OF	n.						
E	reaulting in deeth) LAST			,-				i l		
빙		d								
	PART II. Other significent condition	ns contributing to deeth	but not resulting i	n the underlyin	g ceuse given in	Part I. 24a, WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS		
EDICAL	Hypo thypor	dion				1 YES	. /	AWAILABLE PRIOR TO COMPLETION OF CAUSE		
MEC							1	OF DEATH?		
	DID TOBACCO USE CONT	RIBUTE TO CAUSE (OF DEATH YE	S NO [UNCERTAIL	N KI				
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT							
Sic	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	tpatient 3 DOA	OTHER:	e 5 🗆 Residence	8 Other (Specify)				
РНҮ	27. MANNER OF DEATN	280. DATE OF INJURY		E OF 28c. IN.	URY AT	28d. DESCRIBE HOW	INJURY OC	CURED		
>	1 Destural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO					
0 8	3 Suicide 6 Could not be	26e. PLACE OF INJUR	Y — At home, term, s	treet, factory, offic	•	281. LOCATION (Stree	and Number	r or Rural Route Number,		
Ш 4 ☐ Homicide determined determined										
	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piecs, end due to the ceuse(s) end manner as stated.									
COMPL	(Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check one									
8								to couse(s) end mariner as stated.		
8	////				29c. LICENSE NUI	WBER		E SIGNED (Month, Day, Year)		
2	10. HAME AND ADDRESS OF PERSON WE	ou mo	EATH ATTICAL ATTIC	Orders	130	610	M	lay 8, 1995		
	5602 Shields	Dr., Bethe	sda, Md.	20870	Dr. Tho	mas J. Mc	Namar	a		
	MAY 11 199	32. MEGISTRAR'S SIG	NATURE							



inial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans important. It item 28 is marked, or item 23 shows any injury or what items is the property of t

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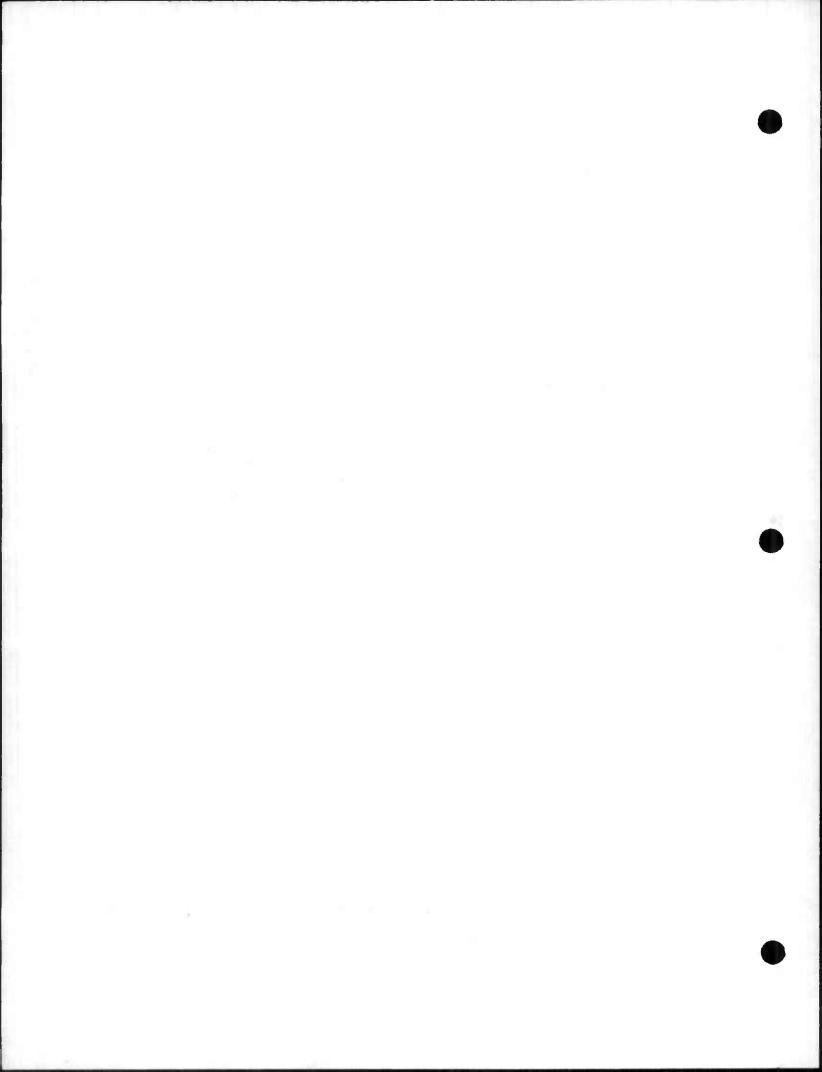
31. DATE FILED (MONTH, Day, Year)

MAY 12

32. REGISTRAP'S SIGNATURE

								95)	5885			
1 - FOR STATE REGISTRAR	STATE OF N			RTMENT OF			MENTAL HYGIEN						
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH			
KATHLEEN	MARIE	BI	UCKS	HAW			MAY 05	AY 1 0 0 F	YEAR	23:59 P			
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les					7 DATE OF BIRTH			LACE (State or Foreign			
217-86-8780	1 □ M 2 😾 F	22	MONTHS DAYS	HOURS	MIN.	Nov 7, 19	72	MD Country))				
9e. FACILITY NAME (If not institution, give			YRS.	A 0774 7045									
				96. CITY, TOWN	OR LOCATI	EATH	9c. COUNTY OF DEATH						
9975 HARVEST I	DR.	Frederick						FF	REDER	ICK			
10a. STATE 10b. COUN	TY		10c CIT	Y, TOWN OR LOCA	TION			- "		and minime nerv			
MD Fred	erick			ederick	IIION				12	10d, INSIDE CITY LIMITS? 1 YES 2 NO			
100. STREET AND NUMBER 9975 Harvest Dri	ve			10	r. zip codi 217				TIZEN OF WI	HAT COUNTRY?			
11. MARITAL STATUS													
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 N	PR IN U.S. ARMED (ES 2 NO IR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:					or No—	14. RACE Black, Specify	- American Indian, White, etc. White			
15. DECEDENT'S ED	UCATION	16a. DE	CEDENT'S	USUAL OCCUPATI	ON		16b, KIND OF BU	SINESS/IN	DUSTRY				
(Specify only highest grad	le completed) College (1-4 or 5 +	life.	ive kind of Do NOT u	work done during m se retired.)	ost of working	ng							
9	Housewife				Housew	ife							
17. FATHER'S NAME (First, Middle, Last) Grover Dale Stanton				-11110									
							ME (First, Middle, Maiden						
					Susan Kro								
19e. INFORMANT'S NAME (Type/Print)			own, State, Zip Code)										
Joseph Ashwal		8	010	Glendale	Driv	ve :	Frederick	MD 2	1702				
20a. METHOD OF DISPOSITION Description 2 Comments 3 Reg	moved from State			OF DISPOSITION (N	ame of		DATE 20c. LO	CATION -	- City or Tow	n, State			
4 Donation 5 Other (Specify)	TOTAL TOTAL STATE	Mt. Te		on Cemet	erv		5-9 Ade	lphi	MD				
21. SIGNATURE OF FUNERAL SERVICES.	CENTEE			22. NAME A		SS OF FA		IDIII	TID				
				Edwar	d Sac	gel E	Funeral Di:	rect	ion				
Elle 5				1091	Rocks	7i 11e	Pike Ro	ckvi	lle M	20852			
23. PART I. Enter the diseases, or complicatione that caused the desth. Do not enter the mode of dying, such as cerdica or respiratory street,													
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disesse or condition	. SHOTI	a or luc	MUC	OF HAT	00					i			
resulting in death)									1				
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Sequentially list conditions,	b. DUE TO	DUE TO (OR AS A CONSEQUENCE OF):											
If sny, issding to immediate cause. Enter UNDERLYING				,						Ī			
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resulting in deeth) LAST		(01171071 0011020	JOENUE O	. ,.						Ĭ.			
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PART II. Other significent condition	ns contributing to	deeth but not re	eeulting	in the underlyin	g ceuee g	given in	Part I. 24a, WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS			
							PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE			
							1 9 YES 2	□ NO		OF DEATH?			
DID TOTAL 000 1100 0010									1	YES 2 NO			
DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH Y	S NO	UNC	ERTAIN	1 🗆 📗						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 NO SPITAL: 1 Input of Death 1 Input of Death 26. PLACE OF DEATH (Check only one) EXAMINER? 1 No OTHER: 1 Input of Death 28. DATE OF INJURY 280. DIME OF DEATH 280. DESCRIBE HOW INJURY OCCURED 1 INJURY 280. DESCRIBE HOW INJURY OCCURED 1 INJURY 280. DESCRIBE HOW INJURY OCCURED 1 INJURY 280. DESCRIBE HOW INJURY OCCURED 1 INJURY 280. DESCRIBE HOW INJURY OCCURED 1 INJURY INJURY 1 INJURY 1 INJURY INJURY 1 INJURY 1 INJURY 1 INJURY 1 INJURY 1 INJURY 1 INJURY 1 I													
1 X YES 2 □ NO	1 Inputlant 2	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Hor	ne 5X Re	aldence	8 (Other (Specify)						
27. MANNER OF DEATH	28s. DATE OF		28b. TIM		JURY AT		28d. DESCRIBE HOW II	NJURY OC	CURED				
1 Natural 5 Pending	(Month, Di	OI S		WY W	PRK?	/NO	Subjec	- 51	105				
2 C Butalda	28e. PLACE O	F INJURY — At hor	me, farm,	street, factory, offic			28f. LOCATION (Street a			uta Number			
4 Momicide determined determined determined						-0	12						
29a. CERTIFIER		-					9925 ADGN		UZ HE	FDERICUL LI			
(Check only 1 CERTIFYING PHY							to the cause(a) and men						
2 (XMEDICAL EXAMIN	ER: On the basis of ex	ramination and/or in	nvestigstic	n, In my opinion, o	desth occur	ed at the	time, date and place, an	d due to t	he ceuse(a)	end manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIE	P ()				29c. LICE	NSE NUM	SE NUMBER 29d. DATE SIGNED (Month, Day, Year)						
1 Wall To hal	X 00 00				OCM					6,1995			
30, NAME AND ADDRESS OF THISON W	HO COMPLETED CAUS	SE OF DEATH (ITEM	1 27) /5ma	(Print)	0011				711	0/1000			
38. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	E OF DEATH (ITEN	# 27) (Type	Print)					0.1				

111 Penn Street, Baltimore, Maryland 21201



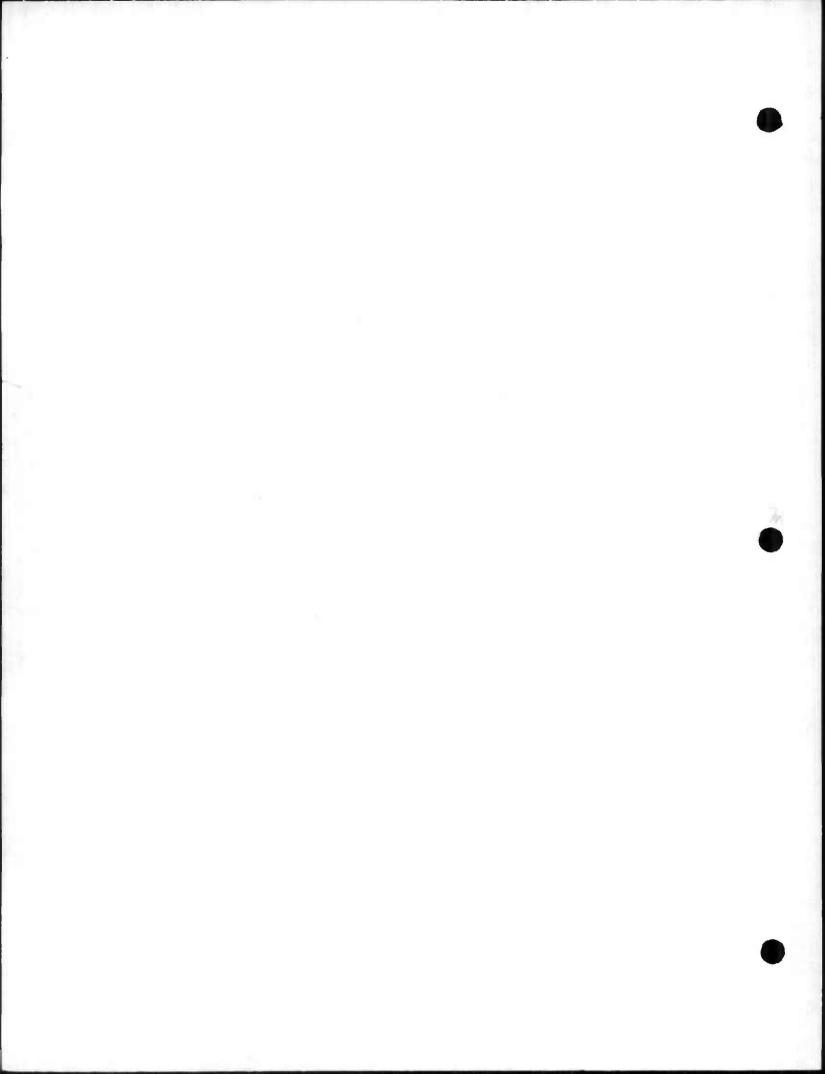
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fronts after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Memai Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF				3. TIME OF DEATH
	Roberta Ballenzweig 4. Social Schurity Number 5. SEX 6. AGE (In v.									_	May 7, 1995 4:0			4:00 P. m
	112-26-4580		5. SEX 1 M 2 F	6. AGE (In yrs. Is	st birthday) YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, D Aug 8	BIRTH ley, Year)	33	8. BIRTH Countr	PLACE (State or Foreign Y) YOU'K
	90. FACILITY NAME (If not in		treet end number)	01		9b. CIT	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA							
DIRECTOR	Howard Coun		eral Hos	pital		Columbia Howar								
<u>D</u>	10e. STATE	10b. COUNT	γ		10c. CI	ry, town	OR LOCA	TION						10d. INSIDE CITY
	MD	Mont	gomery		Silver Spring						LIMITS?			
AL	10e. STREET AND NUMBER				10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?			
l iii	2 Winding W	aye Co	urt		20902				USA					
FUNERAL	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A						IIC ORIGIN? (S	Specify Yes	or No-	14. RACE Black	- American Indian, t, White, etc.
₽	3 Widowed 4 Divo		IF YES, GIVE V			1 Yes 2 NO Specify:						Speci		
		EDENT'S EDU			ECEDENT'S					16b, KI	ND OF BUS	SINESS/INI	DUSTRY	WIIZOG
COMPLETED	Elementary/Secondary (6		College (1-4 or 5		Do NOT u	ise retired.)	during me	ast or wond	ng					
MP	12				Secr	etari	lal			Ва	nkin	g		
8										ME (First, Midd		Sumame)		
H	Isaac Levy									a Cohe				
2	198. INFORMANT'S NAME (Type/PINI)									Route Number,				
	Emanuel M. Ballenzweig								urt,	Silve	7	-		20902
	1 Buriel 2 Cremation 3 Removal from Spate cemetery, crem									DATE			City or To	
	4 Donation 6 Other (Specify) King D						nori	al G	arder	15-10	Fal	1s C	hurch	ı VA
	Edward Sagel Funeral Direction								ion					
1091 Rockville Pike Rockville MD 208									1D 20852					
	23. PART I. Enter the di ehock, or h	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cerdisc or respiratory errest, ehock, or heart fellure. List only one cause on each line. Approximate interval Between												
	IMMEDIATE CAUSE (Fine)												Onset and Daath	
	disease or condition a. Septic shock a. Septic shock Due to (or as a consequence or):													
			DUE TO	(OR AS A CONSE	OUENCE O	IF):								
CERTIFICATION	Sequentially liet conditi	ions,	b. UTI	and pne	umon:	ia								
Ä	If eny, leeding to imme- cause. Enter UNDERLY!	NG												
F	CAUSE (Disease or Inju- thet initiated events	iry	or and	OR AS A CONSE	OUENCE O	iterine cancer								5 months
토	resulting in death) LAS	T (d											
	PART II. Other elapitics	nt condition	e contribution to	double have made		le the co	4.4.	1 33333	and the st					
MEDICAL	TAIL II. Other eigenice	ondition	s contributing to	deetii but not	ot resulting in the underlying ceuse given in Pr					Part I. 24a. WAS AN AUTOPSY PERFORMED?			24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
Ē	<u> </u>									1	YES 2	NO		OF DEATH?
Σ	DID TORACCO II	CE CONITI	DIDLITE TO CA	USE OF DE	T. 1 1/1		F	1		_				1 TYES 2 TO NO
AN	DID TOBACCO U 25, WAS CASE REFERRED TO		KIBUIE IO CA		CE OF DEA			k UNC	ERTAIN	1 1				
PHYSICIAN	EXAMINER?	- Manual Contract	HOSPITAL:			OTHE	R:	, (L) (A)						
¥	27. MANNER OF DEATH		28e. DATE OF		28b. TIN		sing Hom 28c. INJ		sidence	6 Other (S)		THIRD OC	CURED	
	1 Natural 5	Pending	(Month, D		IN.	JURY M	WO	PRK7	ON F	200. DESCRI	IDE NOW II	SONT OC	COMED	
ВУ	3 Sudelde	Investigation	28e. PLACE O	F INJURY — At h	ome, term,	street, fect				28t. LOCATIO	ON (Street o	nd Number	r or Burni D	nute Mumber
TED	_ 。_	Could not be determined	building,	etc. (Specify)			,				own, State)	no repinde	Of Horar H	oute Number,
12	29e. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowledge. de	esth occum	ed at the P	ime, date	and place	and due	to the council	e) and men	Opt on state	ted	
29e. CERTIFIER (Check only one) 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner ee stated. 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner.							end menner es stated.							
ш	296. SIGNATURE AND TITLE	OF CERTIFIER	M					29c. LICE	ENSE NUM	BEA		29d. DAT	E SIGNED	(Month, Day, Year)
m May 7														
유	30. NAME AND ADDRESS OF	PERSON MA	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type	, Print)							. ,	
	Gary Kazlow	Colu	mbia Med	ical Ce	nter	Co1	umb	ia MT)					
	31. DATE FILED (Month, Day,	Year)	mbia Med	R'S SIGNATURE	0 .0						-			
	MAY 12 1995 Julia Savelen-Rardall													



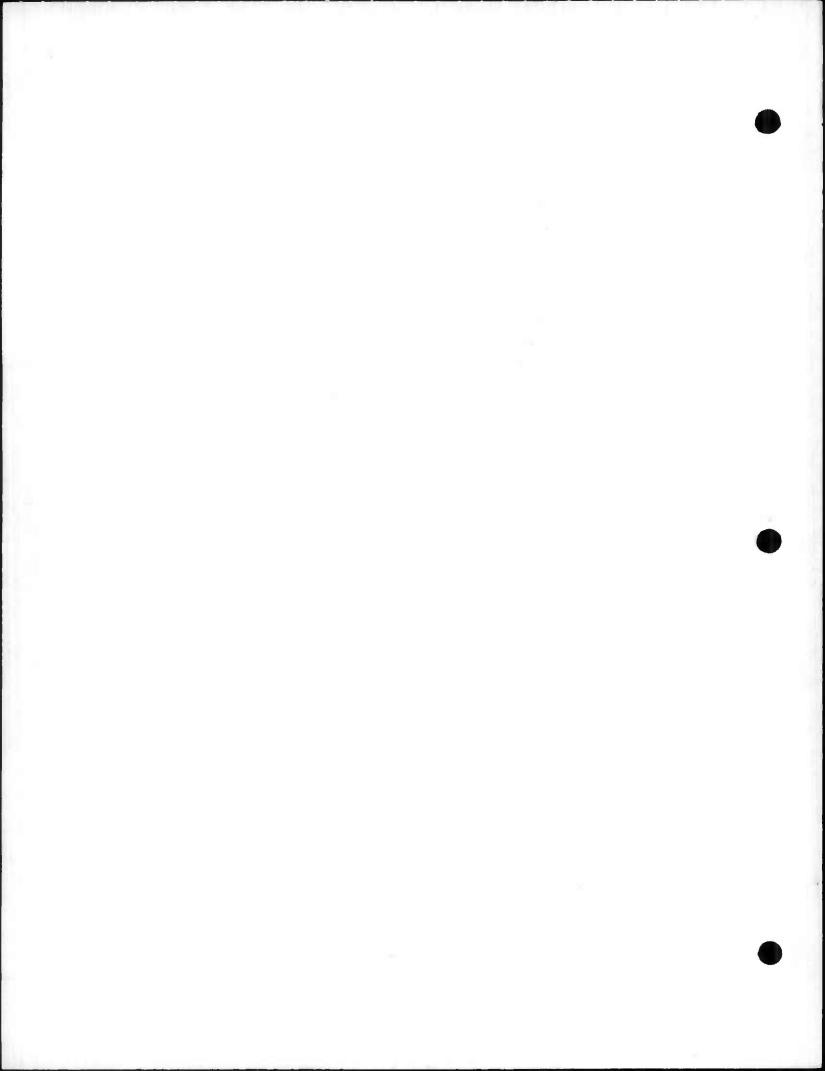
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BALTIMORE, MARYLAND 21215-0020	fler i
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RECORDS, P.O. BOX 68760	requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending obtains
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	DIVISION OF VITAL REF			

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
_		

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE O	F DEATH	RE	EG. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH		3. TIME OF DEATH
	James Alan	Brown					MAY	Q Q	1995	10:35 Am
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. le:	of hirtholous	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		_	
	579-20-9713	1 [X M 2 □ F	72	YRS.	MONTHS DAYS		(Month, Day	Year)	Counti	
			12	THS.				, 1922	Mar	yland
	9a. FACILITY NAME (If not institution, give a	street and number)				OR LOCATION OF			OUNTY OF D	
Ю	302 Dale Drive				Silv	er Sprin	g	M	lontgo	mery
ਹ	RESIDENCE OF DECEDENT									
DIRECTOR	10a. STATE 10b. COUNT				Y, TOWN OR LOC					10d, INSIDE CITY LIMITS?
	Maryland Mo	ntgomery		S	ilver S	pring				1 X YES 2 NO
7	10e. STREET AND NUMBER					of, ZIP CODE		100.0	CITIZEN OF V	WHAT COUNTRY?
8	302 Dale Drive					20910				SA
FUNERAL	11. MARITAL STATUS	12 WAS DECEDENT	EVED IN U.S. AS		40 11110 0					
F	1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1 [YES 2 1	NO	If yea,	CENDENT OF HISPA specify Cuban, Mexic	INIC ORIGIN? (Sp an, Puerto Ricen,	ecify Yes or No- , etc.)	- 14, RACI Bleck	E — American Indian, t, Whita, etc.
ВУ	3 Wildowed 4 Divorced	IF YES, GIVE WA			1 🗆 YI	S 2 NO Speci	lly:	•	Speci	
	45 DEGENERATE FOR	0.71011	WW II							White
2	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DE	ive kind of w	USUAL OCCUPATION OF COMMENT OF CO	TION nost of working	16b. KJNC	OF BUSINESS	INDUSTRY	
۳	Elementary/Secondary (0-12)	College (1-4 or 5+)			e retired.)					
₹		5+	Lav	vyer				Gover	nment	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N	AME (First, Middle,	, Maiden Surname)	
BE	James A. Brown					Virgin	ia Hart	ig		
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Stree	and Number or Rural			Zin Codel	
2	Joanne B. Brown		1			ve Silve				20010
	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ram	oval Irom State	compton, or	melan, or of	PER DISPOSITION (20c. LOCATION		
	4 Donation 5 Other (Specify)		Arlin	gton	Nationa	1 Cemete	ry 5/12/	95 Arli	ngton	, Virginia
	21. SIGNATURE OF POMERAL SERVICE LIC	prince /	7.0			AND ADDRESS OF F		- 1		
	·///. //	7/16	W.			cis J. C				,
_	mara -	pace	- Car							r. MD 20901
	23. PARY I. Enter the diseases, or o shock, or heart fellure.	complicatione that Liet only one caus	caused the de	ath. Do n	ot enter the m	ode of dying, au	ch as cardiec o	or respiratory	arreat,	Approximata Interval Between
	IMMEDIATE CAUSE (Final	and the same		i						Onset and Death
	disease or condition resulting in death)		oma							2 7
	rosolding in death)	DUE TO (OR AS A CONSE	DUENCE OF):					3 Years
- 1										
CERTIFICATION	Sequentially list conditions,	b. DUE TO (OR AS A CONSE	DUENCE OF	n:					
A	If any, leading to immediate cause. Enter UNDERLYING									i i
유	CAUSE (Diseese or Injury	C. Dire TO (OR AS A CONSEC	NIENCE OF	٠.					
Ē	that initiated events resulting in death) LAST	002 10 (0	M AS A CONSE	JUENCE OF	F					i
E		d								
9	PART II. Other algorificant condition	s contributing to d	eath but not r	aguitina li	n the content of	an annua atuun tu	Death Inc.			A CONTRACTOR OF THE PARTY OF TH
EDICAL		_ continuating to c	COULD DOL HOLL	econting ii	ii the underlyi	ng cause given in	Part I. 24a.	WAS AN AUTOPS PERFORMED?	246.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă							1	YES 2 XNO		COMPLETION OF CAUSE OF DEATH?
Ä										1 YES 2 NO
3	DID TOBACCO USE CONTI	RIBUTE TO CAL	ISE OF DEA	TH YE	SINOI	XI LINCEPTAL	N \square			7 0 100 2 0 110
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check only on					
S	EXAMINER?	HOSPITAL:			OTHER:	,				
≥	1 YES 2 NO	1 Inpatient 2				me 5 X Residence		**		
급	1 Natural 5 Pending	28a. DATE OF II (Month, Day	Vear)	28b. TIME INJU	JRY 28c. III	JURY AT ORK?	28d. DESCRIBE	E HOW INJURY	OCCURED	
B	2 Accident Investigation				M 1 🗆	YES 2 NO				
	3 Suicide 8 Could not be	28s. PLACE OF butlding, et	INJURY At ho	me, farm, si	treet, lactory, off	ce	281. LOCATION	(Street and Num	ber or Rural R	loute Number,
2	4 Homicide datarmined		(City or Tow	n, State)		
۳ ا	29a. CERTIFIER		7							
<u> </u>										
Σ Ⅱ	(Check only one) 1 CERTIFYING PHYSICAL EXAMINE	0.0-16-1	mination and/or i	nvestigation	ı, in my opinion,	death occured at the	time, date and p	lace, and due to	the cause(s)	and manner as stated.
Š	(Check only one) 2 MEDICAL EXAMINE	R: On the besis of axa								
E COMPLETED						29c. LICENSE NU	MBER	29d. D	ATE SIGNED	(Month, Day, Year)
띪	one) 2 MEDICAL EXAMINE							29d. D		
	29b. SIGNATURE AND TITLE OF CERTIFIER Nico U Lee	mD		1 27) (Time	Print)	MD D3		29d. D	S/(
띪	29b. SIGNATURE AND TITLE OF CERTIFIER Wich Label 30. NAME AND ADDRESS OF PERSON WHO	MD O COMPLETED CAUSE	OF DEATH (ITE			MD 103	7967	•	5/11	(Month, Dey. Year)
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER Wich Let 30. NAME AND ADDRESS OF PERSON WHO Nicole Lee. M.D.	MD 0 COMPLETED CAUSE Ward 78	of DEATH (ITEE	Logy			7967	•	5/11	(Month, Dey, Yeer)
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER Wich Label 30. NAME AND ADDRESS OF PERSON WHO	MD 0 COMPLETED CAUSE Ward 78	of DEATH (ITEE	Logy		MD 103	7967	•	5/11	(Month, Dey. Year)



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

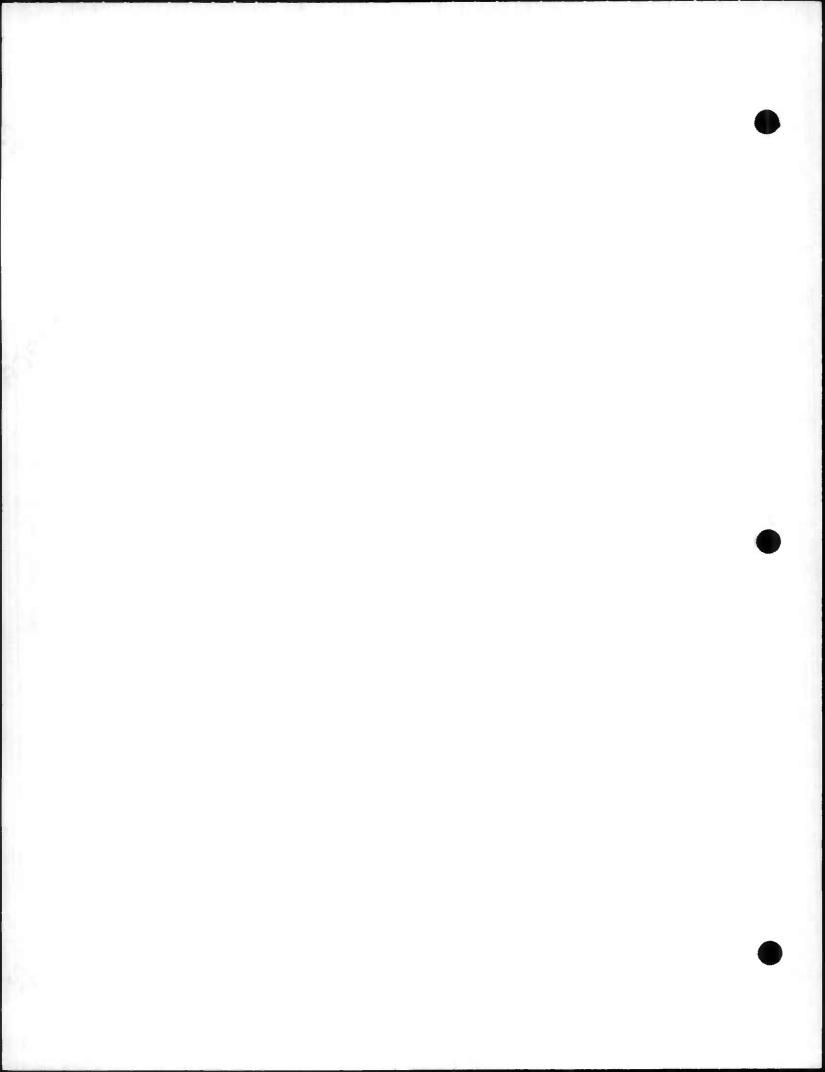
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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First	Added to a cost				TO ATT	- 01	DLA		_	HEG. NO.			
		loward		Burd	ette,	Jr.				2. DATE OF MONTH	DA	Y	YEAR /995	3. TIME OF OEATH
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF	BIRTH			PLACE (State or Foreign
- 1	236-14-3	446	1 🖵 M 2 🗆 F	78	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov.		16	Geor	
	9a. FACILITY NAME (If not in	natitution, give s	treet and number)	70		9b. CITY	, TOWN E	OR LOCATI	ON OF DE		7,17.		NTY OF D	<u> </u>
E	Potomac Va	1107 1	Jurcine L	Iomo										
ΚI	RESIDENCE OF DEC	CEDENT	vursing r	tome		K	ockv	ille				Moi	ntgom	ery
DIRECTOR	10a. STATE	10b. COUNTY	1		10c, CIT	Y, TOWN (OR LOCAT	TION					T	10d. INSIDE CITY
<u>-</u>	Maryland	Mor	ntgomery			Sil	lver	Spr	ine					LIMITS?
	10e. STREET AND NUMBER							ZIP COD				10g. CIT	IZEN OF W	THAT COUNTRY?
FUNERAL	15201 Westh	olm Co	nurt					209	06			II	.S.A.	
2	11. MARITAL STATUS	IOIM OC	12. WAS OECEDEN	T EVER IN U.S. A	RMED	13.	WAS DEC			NIC ORIGIN? (Specify Ven			— American Indian,
	1 Never Married 2X		FORCES? 1	X YES 2 T	NO	1 3	If yes, sp	ecity Cube	n, Mexica	in, Puerto Rici	en, etc.)		Black Specif	, White, atc.
B	3 Widowed 4 Divo	rced		45-Dec	1945			2- [] 110	арволу	y.			Speci	White
		EDENT'S EDUC y highest grade	CATION	16a. C	ECEDENT'S					16b, KI	ND OF BUS	INESS/INI	DUSTRY	WIIICC
	Elementary/Secondary (0		College (1-4 or 5	- 4	Give kind of a fe. Do NOT us	nork done	aunng mo	IST OF WORK	ng					
린			2	Or	tomet	rist				Oph	thal	nolos	V	
COMPLETED	17. FATHER'S NAME (First, M	liddle, Lest)						18. MOT	HER'S NA	ME (First, Mid				
BE	Otis Howard	Burde	ette. Sr.					Mo	onta	10	lcKin	iev		
	19a. INFORMANT'S NAME (7		One was		9b. MAILING	ADDRESS	S (Street a			Route Number,			Code)	
2	Thelma D. H	Burdett	:e											land 20906
	20a. METHOD OF DISPOSIT 1 ☐ Burial 2 ☐ Crematic	ION		20b. PLACE	AND OATE	OF OISPOS	SITION /Na	me of		DATE	20c. LOC	CATION	City or To-	en State
	4 Donation 5 Other	on 3 ⊔ Ramo (Specify)	oval from State	Metro	polit	ther place)	rem	ator	v 5.	/12/95	Alex	candi	ria.V	irginia
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	7. /	n	22.	NAME AF	ID ADDRE	SS OF FA	CILITY				
	· mi	1	1	1/1						llins				
-	20 00000	Mur	- 11 -	12.1		50	00 U	nive	rsit	y Blvd	.,W.	Sil.	Spr.	,MD 20901
- 1	23. PART I. Enter the d ahock, or h	eart fallure.	Liat only one cau	t caused tha d ise on each lir	leath. DD r le.	ot enter	the mo	de of dy	ing, suci	h aa cardia	c or reapir	ratory an	rest,	Approximata Interval Between
- 1	IMMEDIATE CAUSE (Fir	nal	4			,	,							Onest and Death
	disease or condition resulting in death)	→ ,	A	trance	α l	read	- a	nd	neck	k ca	ucer			years
İ			DUE TO	(OR AS A CONS	EOUENCE O	F):								
2	Sequentially list condit	lons T	b											
Ĕ	if any, leading to Imme- cause. Enter UNDERLY	diate	DUE TO	(OR AS A CONSI	EOUENCE DI	F):								
3	CAUSE (Disease or inju		DUE TO	(OR AS A CONSI	POLIFILIDE OF									
CERTIFICATION	that initiated events resulting in death) LAS	т	DOE 10	(UH AS A CONSI	EQUENCE OF	-):								
			1											1
	PART II. Other algnifica	nt condition	a contributing to	death but not	resulting i	n the un	derlying	cause	given In	Part i. 24	a. WAS AN	WTOPSY	246.	WERE AUTOPSY FINDINGS
CAL	malnutri									- 1	PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
	tracheos	1								— ¹	YES 2.	- NO		OF OEATH?
Σ			DIPLITE TO CA	LICE OF DE	ATLL VE	C 10/1	NO E	1 11116	EDTAIL					1 YES 2 NO
A N	DID TOBACCO U		GBOTE TO CA		CE OF OEAT			UNC	EKIAI	и 🗆 📗		-		
PHYSICIAN:	EXAMINER?	MEDICAL	HOSPITAL:			OTHER	P :							
2	27. MANNER OF DEATH		1 Inpatient 2		-	-			sidence	8 Other (S				
		Pending	26a. DATE OF (Month, D		26b. TIM	URY		RK?		28d. DEŞCR	IBE HOW IN	JURY OC	CURED	
À	2 Accident	Investigation	22 21 127 0					ES 2	NO					
		Could not be determined	28e. PLACE O building,	F INJURY — At h etc. (Specify)	ome, farm, s	street, fact	ory, office	•		28f. LOCATION OF 1	ON (Street ar fown, State)	nd Number	or Rural R	oute Number,
COMPLE			CIAN: To the best of											
5	one) 3 MEDI	CAL EXAMINE	R: On the basis of e	camination and/or	Investigatio	n, in my o	pinion, d	eath occur	red at the	time, data an	d place, end	dua to th	re cause(a)	and manner as stated,
n l	296 SIGNATURE AND TITLE	ор сентупия	00					29c, LICE	ENSE NUM	men .		29d. DAT	E SIGNED	(Month, Day, Year)
20 II	Lavis	16	Kay	no				D	239	111		14	lay 1	1 1995
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

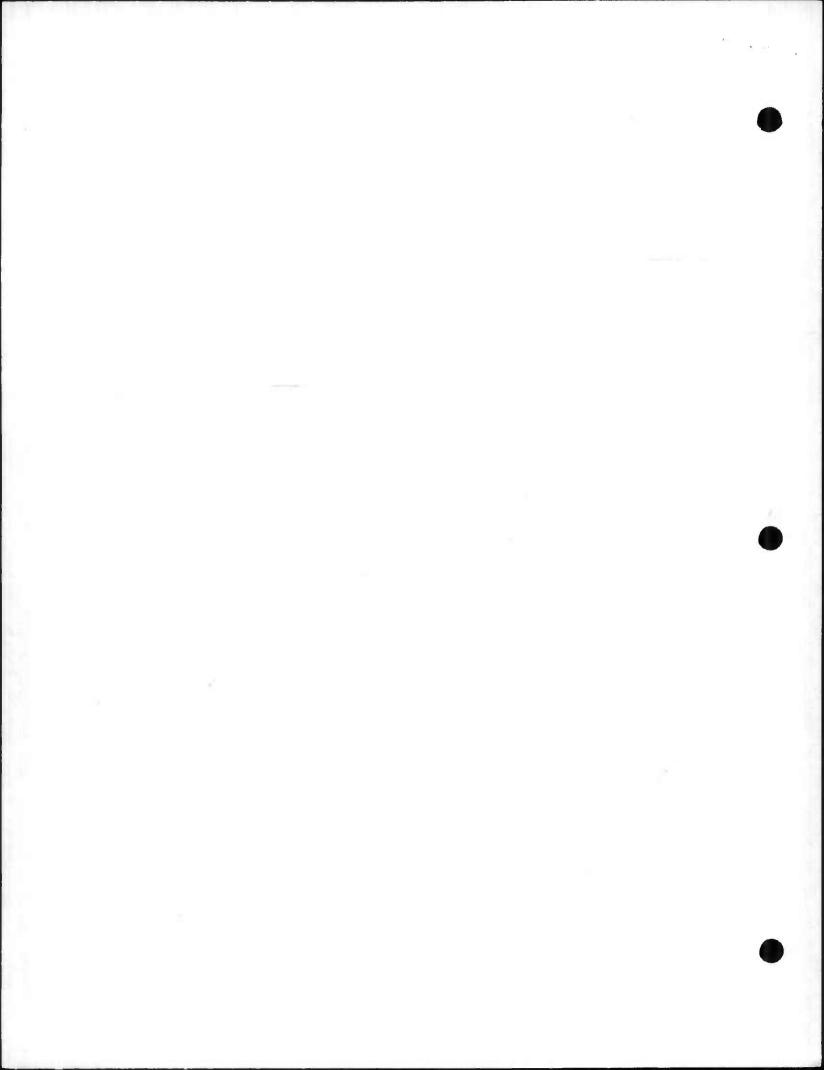
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		3. TIME OF DE	ATH
		FRANK W	lliam			1	BELL	Jr	MONTH D		95 1:28	PW
		4. SOCIAL SECURITY NUMBER		6. AGE (in yrs. las	t birthday)	IF UNDER 1 YEA			7. DATE OF BIRTH		BIRTHPLACE (State of	
		119-30-8310	1 🛛 M 2 🗆 F	54	YRS.	ONTHS DAY	8 HOURS	MIN.	10/21/19	10	Georgia	, or angri
3 should		9e. FACILITY NAME (If not inetitution, give s	treet and number)		1	Bb. CITY, TOW	N OR LOCATI	ON OF DI		9c. COUNTY		
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	111	Frank William	Bell Sr.					07			de Chapm	an
MARY! retained by 5 should be	2	19e. INFORMANT'S NAME (Type/Print)							Route Number, City or Tow			210
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BALTIMORE, I ter death. Page 6 may be in the funeral director, page 5 wal.		20a. METHOD OF DISPOSITION 1 3 Burlel 2 Cremetion 3 Reme	oval from State	20b. PLACE A cemetery, cres	ND DATE OF	DISPOSITION	(Name of		DATE 20c. LO	CATION - CIT	or Town, Btsta	
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DIVISION OR ATTENDING F DIRECTOR: After hours after death item 28 is man												
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TO THE HOSPITAL TO THE FUNERAL DE filed Within 72	8 0	Mr. Cat.	Dell IL	111			0.	C.M.	E.		10,199	
, , , ,	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATHER	27) (Type, Pr	rint)						
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		31. DATE FILED (Month, Day, Year)	32 AEGISTRAR	'S SIGNATURE								
		MAY 1 2 1995	Java da	udian for	fall							

DHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		riedis i tari				CL	MIII	CAIL	OF	DEA	ın	REG. NO			
		1. DECEDENT'S NAME (First,										2. DATE OF DEATH MONTH	w	YEAR	3. TIME OF DEATH
- 1		Vinton	Ells	worth B	aile	V								95	10:35 Pw
1		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (I	n yrs. last	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	T DATE OF BUTTH			IPLACE (State or Foreign
		217-01-37	59	1 🖾 M 2 🗆 F		80	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) NOV. 15,1	014	Count	nr)
		9e. FACILITY NAME (If not in		treet and number)		00		9b. CITY, 1	DOMBI C	D I COST	011 05 05			_	yland
	œ				-			90. GIV,				ATH	9c. COU	INTY OF E	EATH
	CTOR	Fallston	Genera	1 Hospit	<u>al</u>			Fallston Harf			Harf	ord			
	ш	10a, STATE	10b. COUNT	1			10c. CITY, TOWN OR LOCATION								
	E I	Maryland		Harford			100.011								10d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER		narrord				Abin	_						1 YES 2X NO
	₹								101	. ZIP CODI	E		10g. CIT	IZEN OF	WHAT COUNTRY?
ŀ	FUNERAL	814 W. Ba	aker A							2.	1009			US.	A
- 1	5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARN	IED	13. W	S DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RAC	E — American Indian,
	BY	1 Never Married 2 🔀 3 Widowed 4 Divo		IF YES, GIVE V						2 NO		n, Puerto Rican, etc.)		Spec	k, White, etc.
		3 Widowed 4 Divo	rced												White
			EDENT'S EDU			16e. DEC	EDENT'S	USUAL OCC	UPATIO	ON		16b. KIND OF BUS	SINESS/IN	DUSTRY	
		Elementary/Secondary (0		College (1-4 or 5	•)	life.	Do NOT us	rork done du e retired.)	nng mo	ST OF WORKE	ng				
	ᆵ	12				Supe	ervis	sor -	Tr	ansp	orta	tibn	US (Gove	mment
BCG	COMPL	17. FATHER'S NAME (First, M.	iddle, Last)							-		ME (First, Middle, Meiden		30 V C.	LIBICATO
2		William Sa	anner	Bailey						All The Table				+	
96	BE	190. INFORMANT'S NAME (7)		Darrey		1			_				Pres	_	
E .	2											Noute Number, City or Town			
9		Audrey E. I				1 2	314 V	v. Bal	ker	Ave	, A	oingdon, M	d. 2.	1009	
medical examiner must be notified at once.		20g, METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	came	efery crem	atory or of	F DISPOSIT						City or To	
Ē		4 Donation 6 Other			Be	l A	r Me	moria	al (Garde	ens !	5+12 - 95 B	el A	ir. I	Ad.
i i		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE	A			22. N/	ME AN	D ADDRES	SS OF FAC	CILITY			
TEX.		Mish	10	Much	_			HO	var	a K.	MCC	omas III F	uner	al Ho	ome, P.A.
8		2 DATE STATE	1	1.7				13.	L/ (Coke	sbur	y Rd., Abi	ngdo	n, Mo	1. 21009
9		23. PART I. Enter the di shock, or he	art feliure.	List only one cau	se on as	ch line.	tn. Do n	ot enter ti	ie mo	da of dyl	ing, such	n aa cardiac or reapi	ratory ar	rest,	Approximata interval Between
	- 1	IMMEDIATE CAUSE (Fin	nel	4.		,	- /				h				Onaet and Death
t, the		disease or condition resulting in death)	→	. Alyo	car	-di	al	Lo	+	216	112	6.			30 MIN.
other traumatic event,				a. Pue to	(OR AS A	CONSEO	VENCE OF):							
2	z			Cor	ona	14	Ar	for	_	27	CCA	ce.			
ma	으	Sequentially list conditi if any, isading to immed	ona,	DUE TO	(OR AS A	CONSEC	JENCE OF):							
E	₹ I	cause. Enter UNDERLY	NG	AV	(OR AS A	ten.	5/01								
her	RTIFICATION	CAUSE (Disease or Inju- that initiated events	N	DUE TO	(OR AS A	CONSEC	JENCE DF):							
b-		reaulting in death) LAS'	T 📳												
	핑┃														
any injury,	ا ہے	PART II. Other algnifice	nt condition	a contributing to	death bu	it not ra	aulting i	n tha und	erlying	ceuse g	lven in	Part i. 24s. WAS AN		24b	. WERE AUTOPSY FINDINGS
any	EDICAL	· Core.	brove	scular	- D	13 C	se	Hist	Cor	y of		1 YES 2	1.0		AMILABLE PRIOR TO COMPLETION OF CAUSE
SW0		(crobe	ovascula	1 1	Acci.	day of	15				1 163 2	NO.		OF DEATH?
ē	≥	DID TOBACCO U	SE CONTI	PIRLITE TO CA	LISE OF	F DEAT	H VE		ط	11110	EDTAIL				1 YES 2 NO
1 23	PHYSICIAN:	25. WAS CASE REFERRED TO	-	UDUIL TO CA				H (Check on		DIAC	ERTAIN	4 L.			
Item	ত 디	EXAMINER?	4	HOSPITAL:	-			OTHER:							-
10	Z	1 YES 2 HO		1 Inpatient 2	*	rtient 3	DOA	4 - Nursin	_		sidence	6 Other (Specify)			
ed,	ᇤ	27. MANNER OF DEATH		28e. DATE OF (Month, D			26b. TIME INJU		Bc. INJI	URY AT RK7		26d. DESCRIBE HOW II	JURY OC	CURED	
marked,	à I	<i>y</i> -	Pending Investigation					М	1 🗌 Y	ES 2	NO				
-60		2 Pulates	Could not be	26a. PLACE O	F INJURY	— At hom	le, ferm, a	lraet, fector	, office	,		261. LOCATION (Street e	nd Number	r or Rural F	loute Number,
28		4 Homicide	determined		ere: (Opeon	• • • • • • • • • • • • • • • • • • • •						City or Town, State)			
E		290. CERTIFIER	IEVINO BUVEI	Old No. To the book of											
=	물											to the cause(s) and man			
E E	COMPL	2 MEDI	CAL EXAMINE	R: On the basis of s	xamination	and/or In	vestigation	i, in my opi	nion, de	eath occur	ed at the t	time, date end place, and	d due to th	he cause(e) end manner se stated.
E	w 11	296. SIGNATURE AND TITLE	OF CERTIFIER	11		/				29c. LICE	NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
= 1				C/./la	n'	h		Rộn.		L	35	0/2	11/2	1×11	1995
-	임	30. NAME AND ADDRESS OF			SE OF DEA	TH (WEM	27) (Type,	Print)						,	
		J.K	EVIN	LYNC	H	MD		ZN	OR	TH	AV	E. Beli	9ir	m.	rryland
		31. DATE FILED (Month, Day,)	Year)	32 REGISTRA	R'S SIGNA	TURE		_	_						- /
		MAY 1 2	1995	Julia As	and an	Rad									
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ECORDS, P.O. BOX 68/60	quires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy-	signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buri	Health and Mental Hygiene prior to burial, cremation, or removal.
3	Se	igne	eath
L	5	S	I

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MAY 1 2 1995

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31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Methan

30 REGISTRAR'S SIGNATURE

2

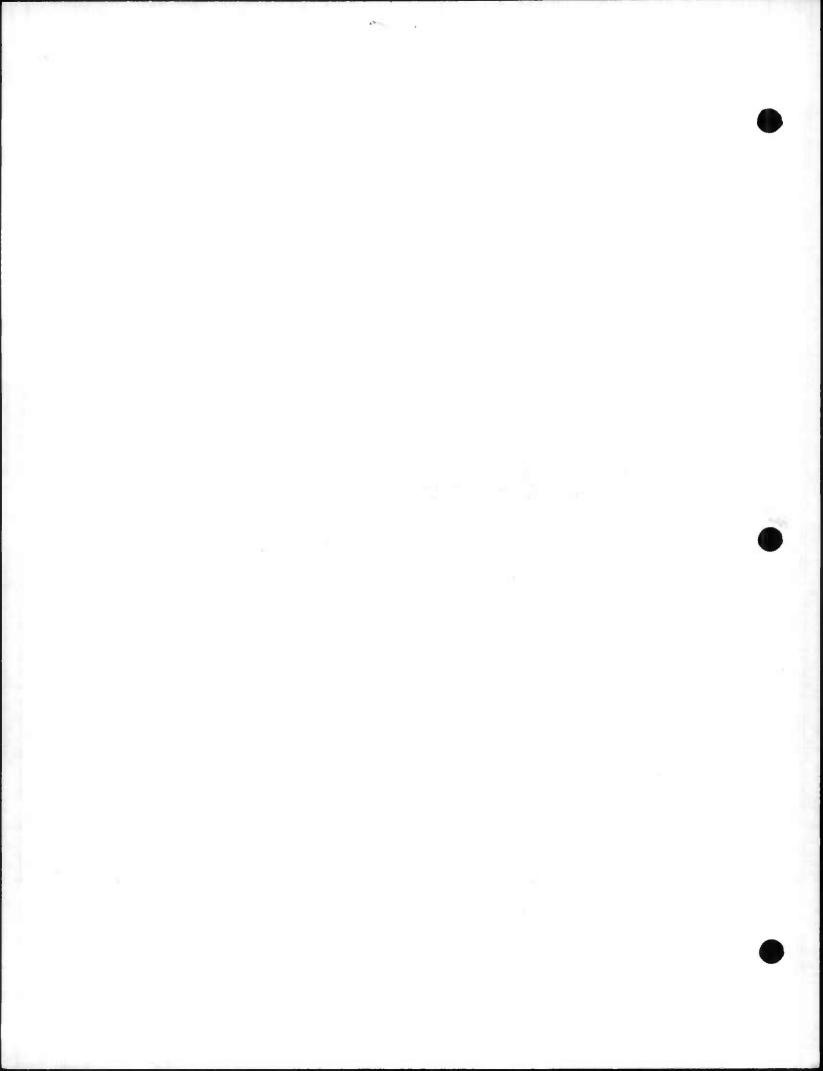
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ila BOXXE Mai 11:05 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Fore (Month, Day, Year) 04-08-1912 260-18-6740 1 - M 2 X F 83 GA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CITIZENS A DIRECTOR Havre Grace de 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MD Cecil Perryville 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 615 Aiken Avenue al-transit 21903 USA sician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 N NO BY Specify: 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Worker Hospital 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Wesley Otto notified at Nancy Groover BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. William Ard 615 Aiken Avenue, Perryville, MD 21903 must be 20a. METHOD OF DISPOSITION
1 ☐ Burlai 2 X Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Before or other place)
Ferris & Co., Inc | 5 4 Donation 5 Other (Specify) 5/11 West Chester, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Betw **IMMEDIATE CAUSE (Finsi** Onset and Death disesse or condition cevu. gestine LWKS resulting in death) injury, or other traumatic event, DUE TO (DR AS A CONSEQUENCE OF) N 1- Schime ardio CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE OF) if sny, leading to immediate cause, Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEDUENCE DF) that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not recuiting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE Calwre Renal. 23 shows any 1 TYES 2 TLNO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WUNCERTAIN I has be Dept. OR ATTENDING PHYSICIAN: The law DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate his with the State [HOSPITAL OTHER: 1 YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ng Home 5 - Residence 6 - Other (Specify) marked, or 4 Norti 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Hatural 5 Pending 1 YES 2 NO After th BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) L DIRECTOR: A hours after de item 28 is 66 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 h (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OR CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mopth, Day, Year) BE

132609

703 Revolution ST

au au 2107

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Pages 1, 2, 3 should

permit.

DIRECTOR

FUNERAL

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COMPLETED

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examiner

BY

COMPLETED

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PHYSICIAN: MEDICAL CERTIFICATION

cause. Enter UNDERLYING

CAUSE (Disease or Injury

that initiated events reaulting in death) LAST

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DIVISION OF VIEW RECORDS, F.O. DOA 19149,	NG	fter	E
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	MIN	PA 2	1 1
	HOS	FUNE	IAN
	뿔	THE PART	OR
	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with?	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely led in by the fune be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exam

									0	12020	
FOR STATE REGISTRAR	STATE OF P	MARYLAN	D / DEPAR CERTIF				MENTAL H	YGIENE EG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF D	EATH DAY	YEAR	3. TIME OF DEATH	1
	Hally I	illia	Beat	tv			_	0, 1995		3:05 p	A
4. SOCIAL SECURITY NUMBER	5. SEX		s. last birthday)	IF UNDE	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		8. BIRTI	HPLACE (State or Foreign	
402 - 90 - 2165	1 🗌 M 2 💢 F	92	YRS.	MONTHS	DAYS	HOURS MIN.	Aug 20	, 1902		ucky	
Se. FACILITY NAME (If not institution, give s	street and number)			9b. CIT	Y, TOWN O	R LOCATION OF	DEATH	9c. CO	UNTY OF	DEATH	
Rockville Nursin	g Home			Ro	ckvil	lle		Mo	ntgor	nery	
RESIDENCE OF DECEDENT											4
10e. STATE 10b. COUNT					OR LOCAT	ION				10d. INSIDE CITY LIMITS?	
	gomery		Ro	ckvi						1 X YES 2 NO	
10e. STREET AND NUMBER					101	ZIP CODE		10g. C	TIZEN OF	WHAT COUNTRY?	
303 Adclare Road					1 2	20850		U	SA		
11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1			13			ANIC ORIGIN? (Sp		14. RAC	E — American Indian,	
1 Never Merried 2 Merried	IF YES, GIVE V					2 NO Spe	ican, Puerto Rican city:				
3 🔀 Widowed 4 🗋 Divorced								33/1		White	
15. DECEDENT'S EDU (Specify only highest grade		164	(Give kind of	work done	e during mo		16b, KIN	D OF BUSINESS/I	NDUSTRY		
Grade 8	College (1-4 or 5		Homema.		,		Own	Home			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S I	NAME (First, Middle	, Malden Surname)		П
Estil Keown						Rosie	Rusher				
19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRE	SS (Street a	and Number or Run	al Route Number, C	ity or Town, State,	Zip Code)		
Alta B. Eddins			11005	Can	dlel:	ight Lar	ne, Poto	omac, Ma	ryla	nd 20854	
20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ☐ Cremation 3 💢 Ren	and from State		ACE OF DISPO	SITION (Name of cer	metery, cremetory o	V	20c. LOCATION	— City or T	own, State	
4 Donation 5 Other (Specify)	IOVER FROM State	Ros	ehill	Ceme	etery		5/15	Owensbo	ro,	Kentucky	
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1	/	1		ND ADDRESS OF					
· WWHY	261	11					neral H			and 20707	
23. PART I. Enter the dispesses or shock, or heart failure.										Approximate Interval Between Onset and Deat	
IMMEDIATE CAUSE (Final disease or condition											Л
resulting in death)	. Cerebr				nt					weeks	
			NSEOUENCE (- ,-							
Sequentially list conditions.	⊾ Parkin									years	
If any, leading to immediate	DUE TO	OR AS A CO	NSEQUENCE (OF):							

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TYES 2 1 NO 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA **EXAMINER?** OTHER:
420 Nursing Home 5 - Residence 6 - Other (Specify) 1 TYES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined 4 Homicide 29e. CERTIFIER

1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D19785

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

809 Viers Mill Road, Rockville, Maryland 20851 Frauke Westphal, MD

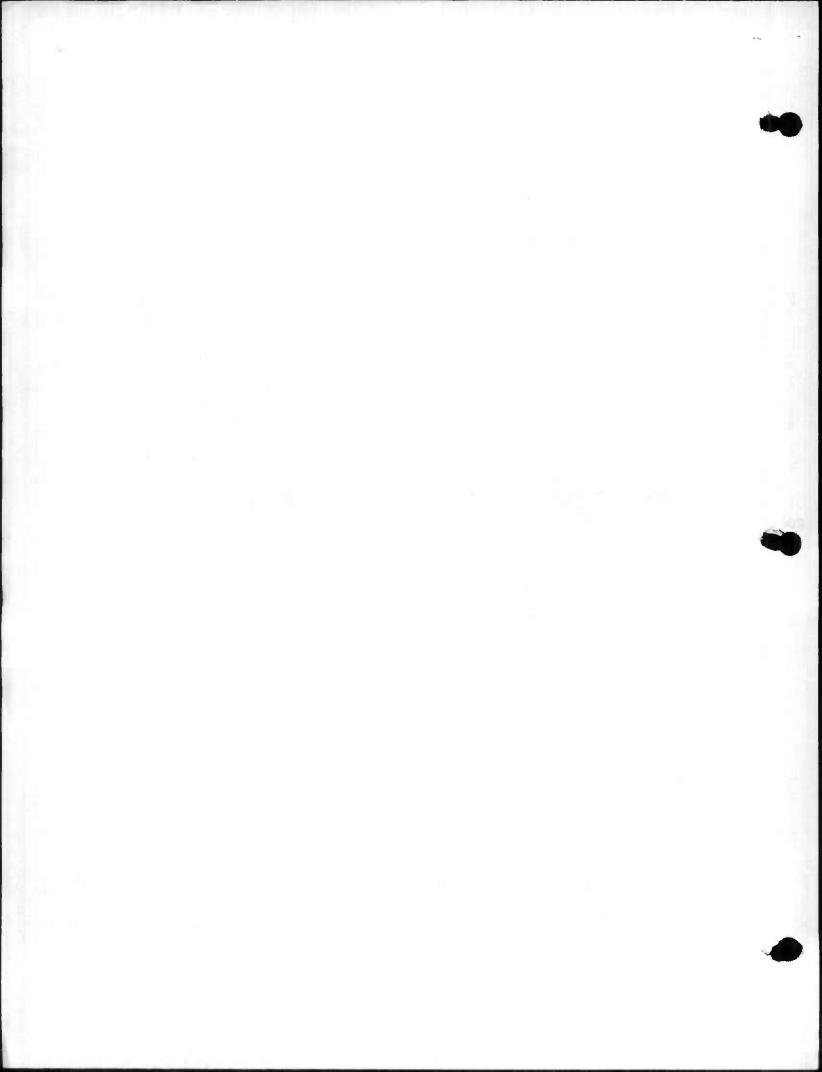
31. DATE FILED (Month, Day, Year) 32/REGISTRAR'S SIGNATURE MAY 1 5 1995

in dandes Randall

May 10, 1995

weeks

24a. WAS AN AUTOPSY PERFORMED?

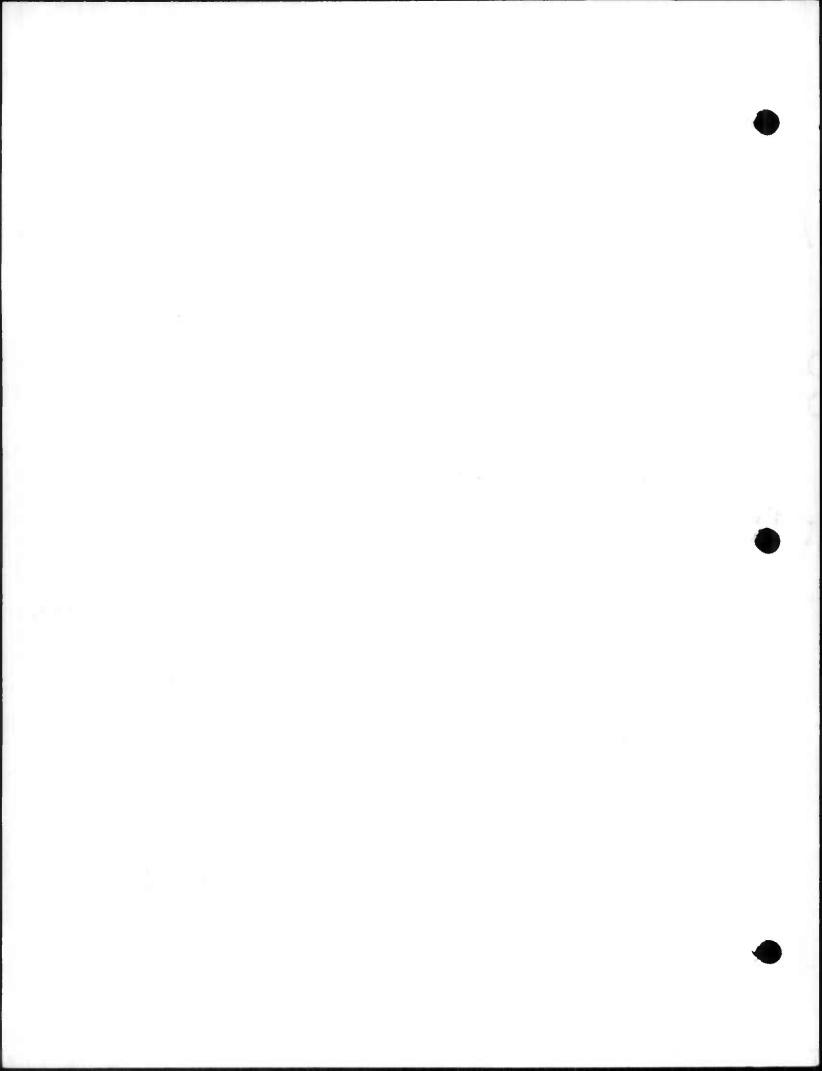


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a second of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1. OECEDENT'S NAME (First, Middle, Last)			MIL UI	DEATH	REG. NO.		
						2. DATE OF OEATH MONTH DA	VE40	3. TIME OF DEATN
, ja	NEVIN		TRIMBLE	BITTN	ER.	May 14.	1995	11:15 p M
- 0	4. SOCIAL SECURITY NUMBER	The second secon		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign
	214-07-4690 9a. FACILITY NAME (If not institution, give a	1	O YAS.		PR LOCATION OF DE	SEPT 8 190		RYLAND
۳ ا	MEMORIAL HOSPITA		"	CUMBEI		AIH	9c. COUNTY OF D	
5	RESIDENCE OF DECEDENT						ADDIO	71.1
DIRECTOR	MARYLAND ALI	LEGANY		OWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 ATYES 2 NO
	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	
FUNERAL	1712 FREDERICK S	STREET			21502		U.S.A.	
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPANI Incity Cuban, Mexican 2 NO Specify:	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	Blac	E — American Indien, k, White, stc.
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEDENT'S US	UAL OCCUPATIO	DN et of working	16b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use n	tired.)		A SILK/M	(A NILLE	
ğ	17. FATHER'S NAME (First, Middle, Last)		GELENASE	CORI		0 2 2 1 1 1		
BE C	JOHN T. BITTNE	ER				NETTE TRIM	-	
10 8	19a. INFORMANT'S NAME (Type/Print) MARY LOU BRUGGEMA	ΔN				oute Number, City or Town		L. 19971
	20s. METHOD OF DISPOSITION 1 Description March Ma		. PLACE AND DATE OF E	ISPOSITION (Na	me of	DATE 20c. LOC	CATION City or To	own, State
-	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		LLCREST C		MAY 17		IBERLAND	MARYLAND
	· Dala L	Memil	,	MERRIT	T-ADAMS	FUNERAL HO REET CUMBE		
CERTIFICATION	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Duylio (or as a public to to a section of the se	CONSEQUENCE OF:	Range CV	Pymux Ab	as cardisc or respi	ratory arrest,	Approximate Interval Batween onset and Death
4	PART II. Other algnificant condition	a contributing to death b	ut not resulting in t	ha underlying	cause given in F	Part I. 24s. WAS AN /		WERE AUTOPSY FINDINGS
MEDIC						1 □ YES 2	No	COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	E DEATH YES		UNCERTAIN			1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF GEATH (Check only one)	011021117111			
Š	1 TES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp		THER: Nursing Nom	5 Residence 8	3 ☐ Other (Specify)		
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	WO	JRY AT RK? ES 2 NO	28d. OEŞCRIBE NOW IN	JURY OCCURED	
	Z Accident Investigation Suicide Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, streetly)	ot, factory, office		281. LOCATION (Street at City or Town, State)	nd Number or Rural I	Route Number,
COMPLET		CIAN: To the best of my know						
	29b. SIGNATURE AND TITLE OF ESTIFIEF	R: On the beals of axamination	n and/or investigation, i	n my opinion, d	ath occured at the 1	1		
	Mulan	w ms			D25406/	D/6041	29d. DATE AVGNED	95 (Sept.)
	30. NAME AND ADDRESS OF PERSON WN William Lamm, M.D				and, Md.	21502	d	
	31. DATE FILEO (Month, Day, Year) MAY 1 6 1995	AFGISTRAR'S SIGN						

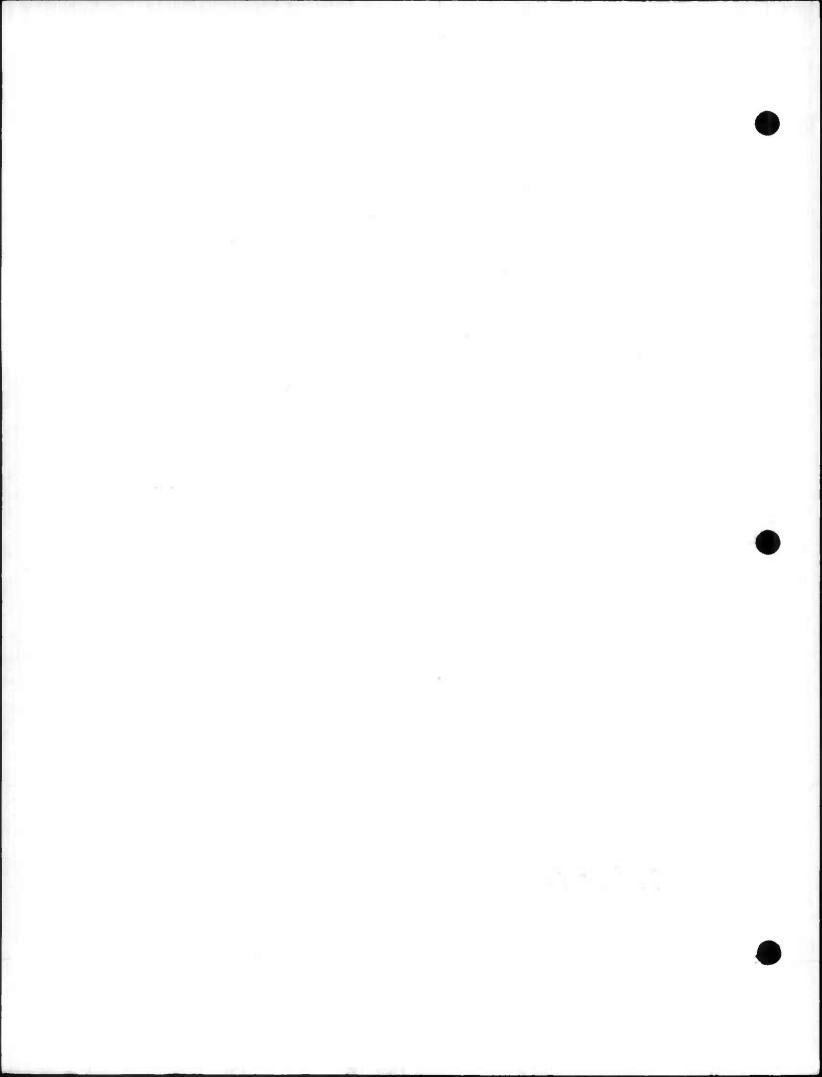


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \$\frac{2}{2}\$ hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	* REGISTRAR				CERTIF	ICALE	: OF	DEAL	H		REG. NO				
	1. DECEDENT'S NAME (First, I	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH													
	Arletta Matilda Bowser							May 6, 1995 (9:25							
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE O	F BIRTH	1000	8. BIRTH	IPLACE (State or Foreign	
	214-74-8856		1 M 2 F	90	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	005	Count	ny)	
	9a. FACILITY NAME (If not inst	titution, give stre	eet and number)			9b. CITY	, TOWN	OR LOCATE	ON OF D					yland DEATH	
E	Garrett Co. Memorial Hospital														
K		RESIDENCE OF DECEDENT						Oakland Garrett							
DIRECTOR						Y, TOWN C	OR LOCAT	TION						10d, INSIDE CITY LIMITS?	
ă	Maryland Garrett				Acc	iden	t							1 YES 2 NO	
FUNERAL	10e. STREET AND NUMBER					10f. ZIP CODE						WHAT COUNTRY?			
	877 Accident-Friendsville Rd.						21520					USA			
Z I	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM					D 13. WAS DECENDENT OF HISPAN				NIC ORIGIN? (Specify Year or No 14 RA				E — American Indian,	
	1 Never Married 2 Married FORCES? 1 YES 2				2 NO	V NO If yes, specify Cuban, Maxica 1 ☐ YES 2 N NO Specify			in, Puerto Rican, etc.) Black				k, Whita, alc.		
B	3 Wildowed 4 Divorced						1 YES 2 NO Specify:							nite	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (GA				6a. DECEDENT'S	CEDENT'S USUAL OCCUPATION				18b, KIND OF BUSINESS/INDUSTRY				1200	
COMPLETED	(Specify only : Elementary/Secondary (0-1			4)	(Give kind of work done during most of working life. Do NOT use retired.)										
7	Elementary/Secondary (0-12) College (1-4 or 5+)			"	Homemaker				Own Home						
NO.	17. FATHER'S NAME (First, Mid	idle, Lasi)					18. MOTHER'S NAME (First, Middle, Maiden Surname)								
	Charles Burl	Charles Burkhardt						Mary Zinkan							
8	19a, INFORMANT'S NAME (Typ.	ne/Print)			19b. MAILING	ADDRESS	C (Ptop et s				. 00	- 0 7	0.41		
2	Loretta Rusl														
	20a. METHOO OF DISPOSITIO								enas					it, MD 21520	
	1 X Burisi 2 □ Cremation	3 Remov	val from State	cemet	ery, crematory or o	E OF DISPOSITION (Name of rother place)				OATE 20c. LOCATION — City or Town, Stata					
	4 Donation 5 Other (- $ $ Zic	on Luth	eran	Cerr	eter	y Ma	y 8,9	5 Ac	rcide	nt,	MD	
	21. SIGNATURE OF FUNERAL	SERVICE LICE	INSEE			eran Cemetery May 8,95 Accident, MD									
	Newman FUneral Homes, P.A.														
	23. PART I. Enter the flis	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	shock, or haert failure. List only one ceuse on each line.								ec or rasp	iratory sr	reat,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition												Onset and Death		
	resulting in death)	nia								3 days					
		DUE TO (OR AS A CONSEQUENCE OF):													
z I	congestive heart failure										2 months				
CERTIFICATION	if any, leading to immedi	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
ଧ୍ର ।	cause. Enter UNDERLYING atherosclerotic cardiovascular disease									3 years					
<u> </u>	thet initieted events		OUE TO	(OR AS A C	ONSEQUENCE O	F):									
	resulting in death) LAS1	resulting in death) LAST										~			
	BART ii Other significan	DATT II Ohbo di sililiant confilire di silili													
록∣										. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
EDICAL	_deep_venous_thrombosis, pneumonia							1 🗆 YES 2			NO NO	NO COMPLETION DF DEATH?			
ME											1 YES 2 NO				
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO														
×	25. WAS CASE REFERRED TO						26. PI	LACE OF O	EATH (C)	eck only one					
PHYSICIAN:	EXAMINER? 1 YES 2 PNO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)														
בׁ	27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIN						28c. IN.	JURY AT		28d. DESCRIBE HOW INJURY OCCURED					
		1 X Netural 5 Pending (Month, Day, Year)				INJURY WORK?			200. DEGOTION HOUSE						
B	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, ferm,								28f. LOCATION (Street and Number or Rural Route Number,						
			28f. LOCATION (Street, factory, office 28f. LOCATION (Str												
<u> </u>	20. CERTIFIER 37														
릴															
COMPLET	one) 2 MEOIC	EXAMINER	On the beele of e	xamination	end/or investigation	on, in my o	pinion, c	deeth occur	ed at the	time, data e	nd place, ar	nd due lo t	he cause(a) and manner as stated,	
U U	296 MICHITURE AND TITLE OF CERTIFIER					29c. LICENSE NU			MBER 29d. DATE SK			E SIGNED	INED (Month, Day, Year)		
00	MMW 8- Murmen				M	M. D25759			▶May 7, 1						
임	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)									2000					
	Walter K. Naumann, M.D., PO Box 247, Accident MD 21520														
- 1	31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year)														
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te ha	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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This s	W	-

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH LEORA BARNCORD 1995 4:48 MRY 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 TF 214-05-6651 MAY 27 1906 MARYLAND 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. IHSIDE CITY MARYLAND ALLEGANY LAVALE 1 X YES 2 | NO FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1202 VOCKE ROAD 21502 S 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X HO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 YES ZY HO Specify: BY 3 Wildowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIHD OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Sumame) ADAM GEORGE LEPLEY CINDIE MURRAY BE 19e. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 OWEN K. BARNCORD ROUTE 3 BOX 386 RIDGELEY, W. VA. 26753 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, State DATE 1 X Buriel 2 Cremetion 3 Removal from State ☐ Donation 5 ☐ Other (Specify) RESTLAWN MEMORIAL GAR. 5/4 LAVALE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AHD ADDRESS OF FACILITY HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heert fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition weels gangiene resulting in death) DUE TO (OR AS A CONSEQUENCE OF 2 runit Deen veury CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AH AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 0 1 YES 2 000 1 YES 2 HO PHYSICIAN: meur 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ffursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 27. MANHER OF DEATH 28c. HJURY AT WORK?
1 YES 2 NO 26a. DATE OF IHJURY (Month, Day, Year) 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED Hatural 5 Pending Investigation BY 2 Accident 3 Suicide 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER
(Check only one)

ASDICAL EVANIMED, On the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 h
IMPORTANT: If it 2 MEDICAL EXAMIHER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)

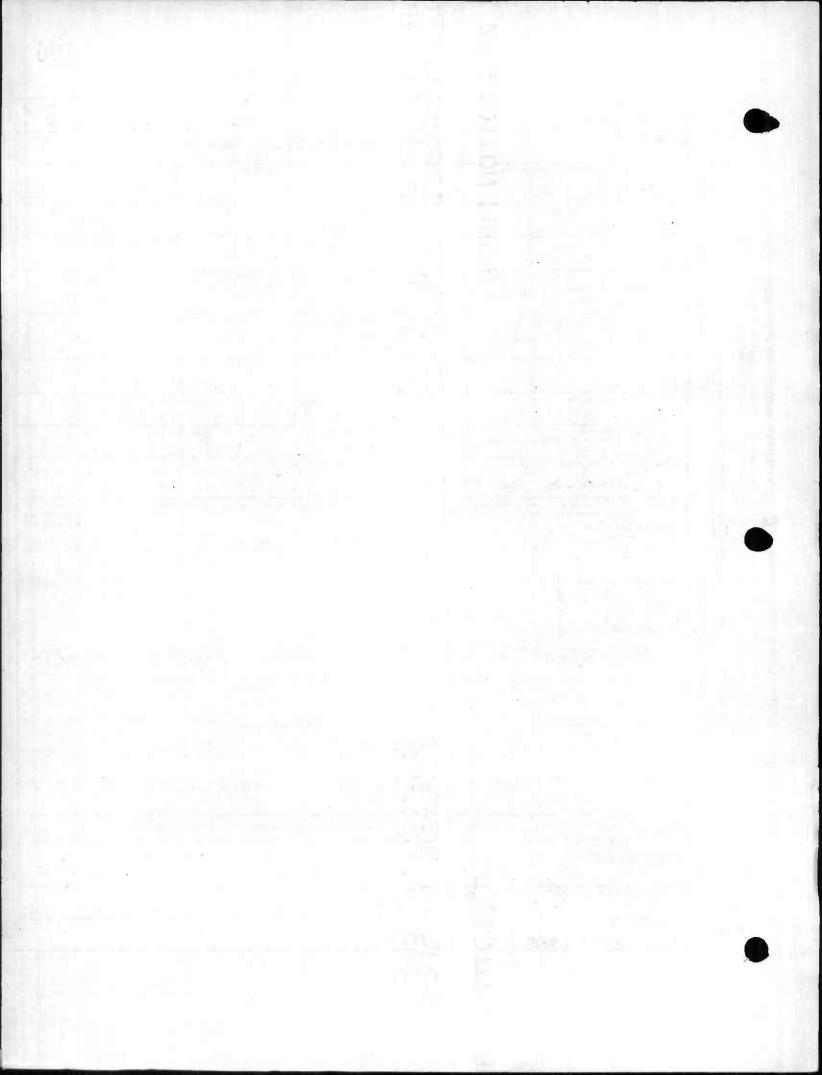
Pray 2. 1995 29c. LICEHSE NUMBER BE The 0

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jan Rarbell

DHMH-18 Rev 1/89



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Amended # 106, 5/19/95, L.H., Fred. Co.

STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)	2. DAT					DATE OF DEATH			TH		
	Annie	Melvina	nher			2 19	YEAR		Ам			
	4. SOCIAL SECURITY NUMBER					7. DATE OF BIRTH			-			
	The of Cartes and States		MC	NTHS DAYS HOURS	MIN.	(Month, Day, Year)		Country)	CE (State or Fo	preign		
	-11 20 3702		30			March 5,1	907	Mary.	land			
	9e. FACILITY NAME (If not institution, give stre	eet and number)	91	b. CITY, TOWN OR LOCA	TION OF DEAT	тн	9c. COUNTY	OF OEATI	н			
1 5	Frederick Memorial Hospital Frederick Frederick											
5	RESIDENCE OF DECEDENT											
DIRECTOR	10e. STATE 10b. COUNTY	<u></u>		OWN OR LOCATION				100	I. INSIDE CITY			
	Maryland Carre	11 trederic	K M	t. Airy,				1 {	YES 2	NO		
A	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT							COUNTRY?				
FUNERAL	1012 Meadowgreen Dr. 21771 United State									28		
13		12. WAS DECEDENT EVER I	. WAS DECEDENT EVER IN U.S. ARMED 13. WAS			ORIGIN? (Specify Ye			American Indi			
	1 Never Married 2 Married	FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		If yes, specify Cut	en, Mexicen,	Puerto Rican, etc.)		Black, W	hite, etc.			
B≺	3 XXWidowed 4 ☐ Divorced	ii res, oire tan on p	ATES	1 TYES 2 XNO	э эреспу:			Specify:	White			
COMPLETED	15. DECEDENT'S EDUCA	ATION	16e. DECEDENT'S US	UAL OCCUPATION	16b. KIND OF BU	16b. KIND OF BUSINESS/INDUSTRY						
1 🖺	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+) (Give kind of the Do NOT use		done during most of worldired.)	king							
1 4	12	Conege (1-4 or 5+)	Homem	akar		Own	Homo					
≦	17. FATHER'S NAME (First, Middle, Last)		Homen		E (First, Middle, Meiden Surname)							
		Janes - Transfer la		277-27			-					
H	George E	dwin Wright			Nannie Pearl Startt							
2	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street end Numb								
	Dawn Eldridge		1012	Meadowgree	n Dr.	/ Mt. Air	y, Md.	217	771			
	20e. METHOD OF DISPOSITION 1 V Burlel 2 Cremetion 3 Remove	val from State	b. PLACE AND DATE OF D metery, crematory or other	DISPOSITION (Name of		DATE 20c. LO	CATION — City	or Town,	State			
	4 Donation 1 Other (Specify)	Ďi	ulaney Val	ley Mem.Ga	rdens	5-15 Tim	onium,	Mary	yland			
	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE	Dulaney Valley Mem.Gardens 5-15 Timonium, Maryla 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Ho									
5	A Ula CA . S	8 E. Ridgeville Blvd./Mt.Airy, Md. 21771										
	Macu VIA	Leigh		8 E. Rid	gevil.	le Blvd./	Mt.Air	y, Mo	d. 217	71		
	23. PART I. Ener the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, and ck, or heart failure. List only one sause on each line. Approximate interval Between											
	IMMEDIATE CAUSE (Finel									d Death		
	disease or condition resulting in deeth) s. DUE TO (OR AS A CONSCOUENCE OF):									2. 1		
	l resulting in deeth)	DUE TO (OR AS	A CONSEQUENCE OF):						101	10		
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CERTIFICATION	Sequentisity list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
X	csuse. Enter UNDERLYING											
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A										
E	resulting in desth) LAST											
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4	PART II. Other significent conditions	contributing to deeth t	out not resulting in t	he underlying ceuse	given in Pa	art i. 24s. WAS AN			RE AUTOPSY F			
DICAL	(0)000 61/4 61/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/								ILABLE PRIOR MPLETION OF (
	Durbala Mal	1 1 10 10										
ME			E DEATH VEC		GED = 4 14 1	_		1 -	1 YES 2 NO			
A N	25. WAS CASE REFERRED TO MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	EXAMINER? A HOSPITAL: OTHER:											
YS		Inpetient 2 - ER/Out		☐ Nursing Home 5 ☐ F	Residence 6	Other (Specify)						
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O		2	26d. DESCRIBE HOW I	NJURY OCCUR	IED				
BY	1 Netural 5 Pending 2 Accident Investigation			M 1 TES 2	□ NO							
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spe	— At home, ferm, stree	et, factory, office	2	281. LOCATION (Street	and Number or i	Rural Route	Number,			
	4 Homicide determined	building, atc. (Spec	Cny)			City or Town, State)						
"	290. CERTIFIER											
₽ E	(Check of the cause) Check of the cause of											
COMPLETED	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated.											
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)											
	6 (4, C) (4) (1/2) (2) (1) (1) (1)								5/1U18 r			
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
	1475 tany are helendo not 21201											
	31. DATE FILED (Month, Day, Year)	31. DATE FILED (Month, Day, Year) 32. REBISTRARS SIGNATURE										
	MAY 1 5 1995	Jalia alteres	yor Real of									
		11	LACTOR									

 FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

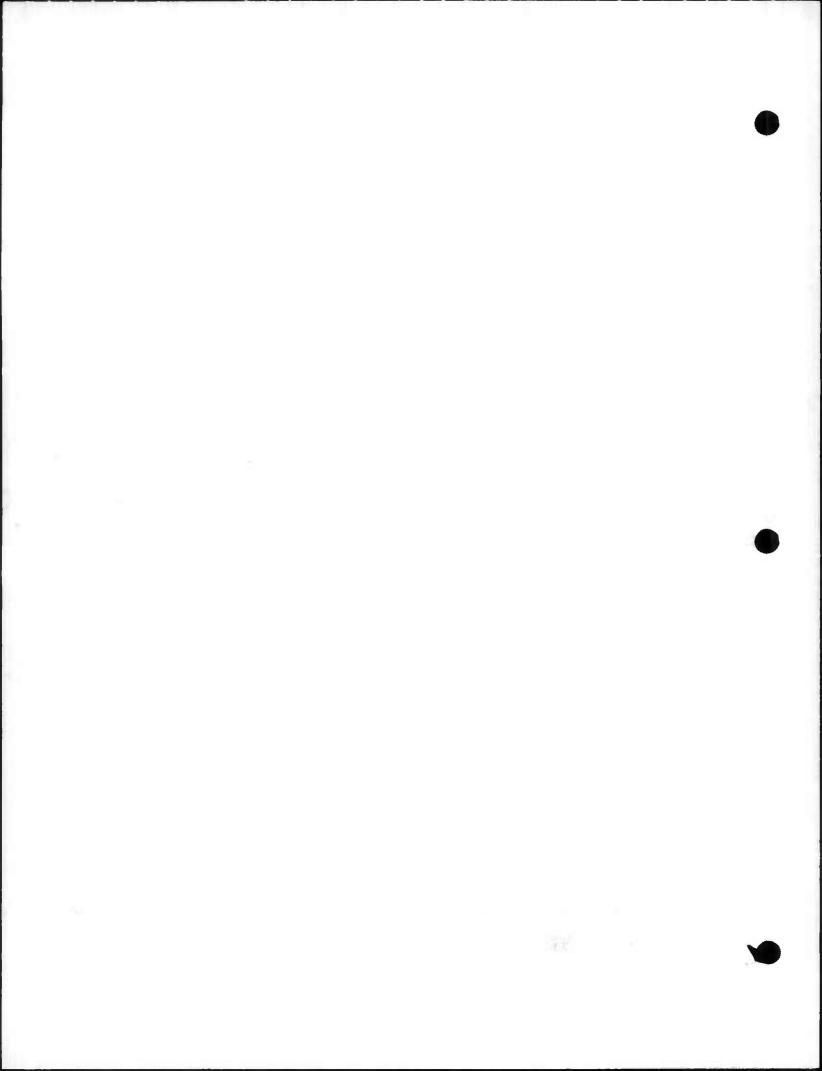
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1. DECEDENT'S NAME (Firs	t, Middle, Last)								2. DATE	OF DEATH	W	YEAR	3. TIME OF DE	EATH					
		udwell		itzhugh		CA	TLE	ΓT		May	11, 1	995	TEAR	1:15	P. 1					
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER	1 YEAR	HOURS	R 24 HRS.		OF BIRTH		a. BIRTH Count	HPLACE (State or	r Foreign					
1 1	577–10–8521		1 XM 2 - F	80	YRS.		- Carre	noons			20, 19	914		Virginia F DEATH Frederick 10d. INSIDE CITY LIMITS? 1X YES 2 \(\text{IN} \) NO F WHAT COUNTRY?						
-	Sa. FACILITY NAME (If not is					9b. CITY		OR LOCAT				9c. COU	NTY OF D							
CTOR	10001 Carr	oll Pa	rkway			L	I	Frede	rick			<u></u>		Freder	ick					
I III I	10a. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN (OR LOCA	ATION						10d, INSIDE C	ITY					
l el	Maryland	Fr	ederick			Fr	edei	rick							Пио					
AL AL	10e. STREET AND NUMBER						10	Of. ZIP COD	E			10g. CIT	IZEN OF	Virginia DEATH Frederick 10d. MSIDE CITY LIMITS? 1X YES 2 NO WHAT COUNTRY? A. CE — American Indian, ck, White, atc. ic/ly: White tries and 21701 Town, State n. Maryland e Md. 21701 Approximata Interval Between						
FUNER	10001 Carr	oll Pa	rkway						2170	1			U.S.	Α.						
1 2	11. MARITAL STATUS	1 884-4		T EVER IN U.S. AF							N? (Specify Yes Rican, atc.)	or No-	14. RACI	E — American Ir	ndlan,					
B	1 Never Married 2 3 Widowed 4 Div	proed	IF YES, GIVE Y	MAR OR DATES				S 2 NO			riiomi, ato.)				e					
<u>a</u>	15. DEC	CEDENT'S EDU		3 - Apri	1 194 ECEDENT'S		CCHPAT	ION		160	. KIND OF BUS	INECC/IN	MICTEN							
	(Specify on Elementary/Secondary (ly highest grade	College (1-4 or 5		live kind of v	work done			ng	1.00	A KIND OF BUS	ME35/M	JUSTAT							
	,	,,	2		cutiv	n Di	rec	tor			Goodwil	ll Ir	ndust	ries						
COMP	17. FATHER'S NAME (First, A	fiddle, Last)		ILAE				-	HER'S NA		Middle, Malden									
ш	Joseph Catl	ett						E11e	en Wi	illia	ams									
9 0	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street	and Numbe	or Rural I	Route Nun	ber, City or Town	n, State, Zip	Code)							
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	20s. METHOD OF DISPOSIT	on 3 🗆 Rem	ovat from State	20b. PLACE cemetery, cre				lame of		DAT	20c. LO	CATION -	City or To	wn, State						
	4 ² Donation 6 □ 9the		DENDER.					M:	y 13	3 1	995 M	idd1e	town	. Mary	1and					
1 1	11. SIGNATURE OF TORER		0 C B	anda l	1	22.														
	- Lu		C.C. U	asfort	00021	. F					rd Fune				1701					
	23. PART I. Enter the d shock, or h	liseasea, or di leert fellure.	complications the	it caused the deuse on each line	eeth. Do r	not enter	the m	स्वरुग रिप	ing, suc	h as cer	diac of reapi	ratory ari	reat,	Approxi	Imate					
	IMMEDIATE CAUSE (Fi		,								,		Interval Between Onset and Death							
	disease or condition a. 4477 - con / c 7 -												5 9							
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CATION	Sequentially list condit		b. DUE TO	(OR AS A CONSE	QUENCE OF	Pi:	/	ULC							7					
Ā	if any, leading to imme cause. Enter UNDERLY	ING	M	0160	1/-	,				- 7				121	11000					
Ē	CAUSE (Disease or Injuthat Initiated events	ary)	DUE TO	(OR AS A CONSE	QUENCE OF	F):			-					1 - 3	1					
CERTIFI	resulting in death) LAS	ST I	d		MSEQUENCE OF:															
	PART II. Other significa	ent condition	a contributing to	death but not	but not resulting in the underlying ceuse given in						24a. WAS AN	ALITORAL	621	. WERE AUTOPSY	d Palamana					
EDICAL	1.50							·g 00000	giveir iii	ranci.	PERFOR	MED?	240	AVAILABLE PRIC	OF TO					
밀		-)							_	1 - YES 2	NO		OF DEATH?						
≥ =	DID TOBACCO U	ISE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S \square I	1 04	PHINO	FRTAIN					1 YES 2	NO					
A	25. WAS CASE REFERRED T				CE OF DEAT		_		LKIAII	10										
PLETED BY PHYSICIAN: MEC	EXAMINER?		HOSPITAL: 1 Inpetient 2	ER/Outpatient 3	□ DOA	OTHER 4 Num		me 5 BR	aldence	6 🗆 Othe	r (Specify)									
	27. MANNER OF DEATH		26s. DATE OF (Month, E		26b. TIM		28c. IN.	JURY AT ORK?			SCRIBE HOW IN	NJURY OC	CURED							
BY F	1 Metural 5 2 Accident	Pending Investigation	(Month, 2	ray, rour,	1165	M	_	YES 2] NO											
0	3 Suicide 6	Could not be	28e. PLACE C building,	F INJURY At he atc. (Specify)	ome, farm, s	street, tect	ory, offic	ce		261. LOC	ATION (Street a	nd Number	or Rural F	Route Number,						
ETE	4 Homicide	determined																		
MPL		TIFYING PHYSI	CIAN: To the best of	my knowledge, de	ath occurre	ed at the t	lme, date	a and place	, and dua	to the ca	use(a) and man	ner aa stat	led.							
COM	one) 2 MED	ICAL EXAMINE	R: On the basis of a	xamination and/or	investigatio	n, in my o	pinion,	death occu	red at the	time, date	and place, and	d dua to th	na Cause(a	i) and manner at	stated.					
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER	- //					29c. LIC	ENSE NUN	ABER		29d. DAT	E SIGNED	(Month, Day, Yea	nr)					
TO B	13		2/4					10	180	2	c		May	12, 19	995					
-	30. NAME AND ADDRESS O						1.1.	Q1		7		1/-								
	P. Gregor	y Kaus	cn, M.D.	, 501 We	est S	even	th :	stree	et, F	rede	erick,	Mary	Tand	1 21/01						

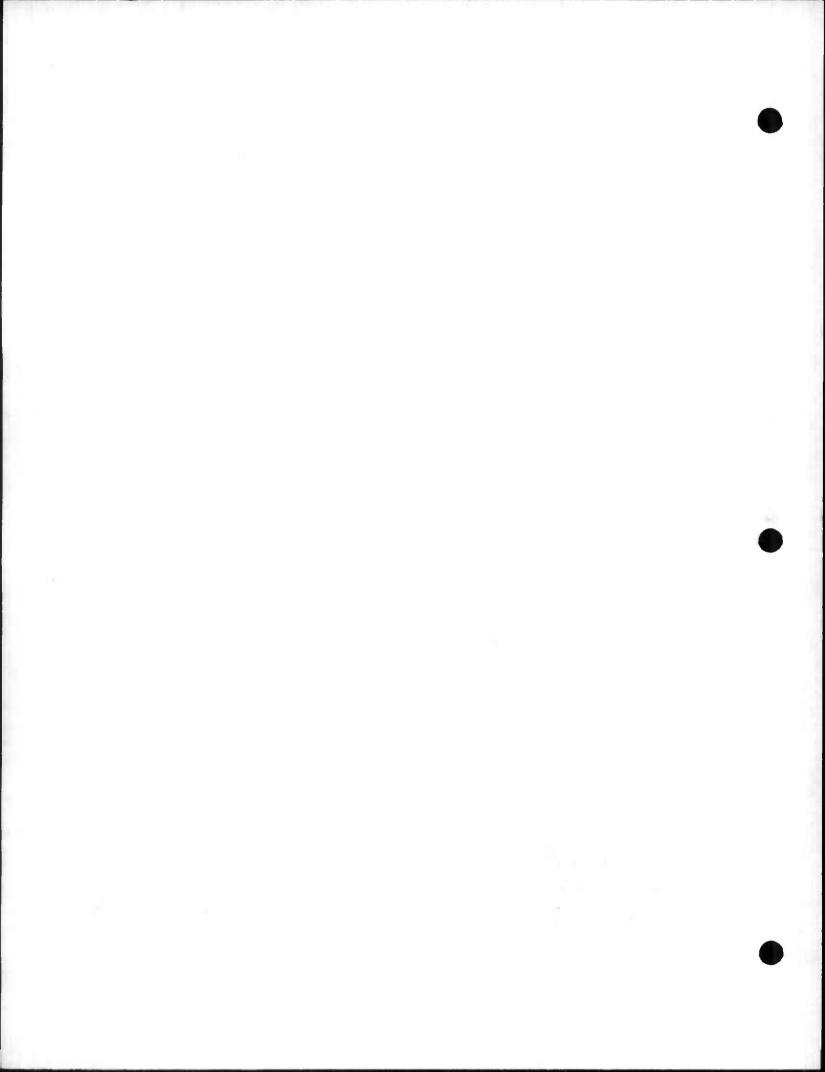
32. REGISTRAR'S SIGNATURE
July Olivelson Reveal

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



DECEMBER AND PERSONAL MATERIAL PROPERTY AND ALLEY AND AL	D MENTAL HYGIENE REG. NO.
THE STATE OF COUNTY OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF STATE OF COUNTY OF	2. DATE OF DEATH MONTH 1995 YEAR 2:15 P. M
Mediplex of Montgomery Village Gaithersburg Montgomery Montgomery	Feb. 24, 1916 Country) New York
19301 Watkins Mill Road 19301 Watkins Mill Ro	DEATH 9c. COUNTY OF DEATH Montgomery
BY Wishowed Diverced 1943-1946 1943-	10d. INSIDE CITY LIMITS? 1XX YES 2 □ NO
BY Wishowed Diverced 1943-1946 1943-	10g. CITIZEN OF WHAT COUNTRY? United States
STOTIAMO CONSTANTIANAME (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North North No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Nor	clcan, Puerto Rican, etc.) Black, White, etc. Specify: Specify:
STOTIAMO CONSTANTIANAME (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Potomac, No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North North No. Market (PyraPrint) 12.37 Hidden Brook Terrace, North Nor	->
Anthony Constantino (son) 12137 Hidden Brook Terrace, North Potomac, Now. Market and Proceedings of the Control of Disposition (son) 20, METHOD OF DISPOSITION 10 Disposition 10 Disposi	Cosenza
Vivinitian 2 Commention Removat from State Counting Control 2 Counting	errace, North Potomac, MD 20878
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. IMMEDIATE CAUSE (Final diseases or condition) a. Hypoxia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, farry, leading to immediate cause. Enter UNDERIVING AUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL ENAMINERY: 1 YES NO 27. MANNER OF DEATH 1 YES NO 28. MANUERY 26. DATE OF INJURY 28. THATE OF DEATH 27. MANNER OF DEATH 28. DATE OF INJURY 28. THATE OF DEATH 29. DATE OF INJURY 28. THATE OF DEATH 29. CENTIFIER NO 28. MANUER OF DEATH 29. CENTIFIER NO 28. MANUER OF DEATH 29. CENTIFIER NO 28. DATE OF INJURY 29. DATE OF INJURY NO 28. MANUER OF DEATH 29. CENTIFIER NO 28. DATE OF INJURY 29. DATE OF INJURY NO 28. MANUER OF DEATH 29. CENTIFIER NO 28. DATE OF INJURY 29. CENTIFIER NO 28. DATE OF INJURY 29. DATE OF INJURY NO 28. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY 29. DATE OF INJURY NO 29. DATE OF INJURY	ry 5/8 Pinelawn, New York
MMEDIATE CAUSE (Final disease or condition resulting in death)	
Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter UNDERTYING CAUSE (Pisease or Injury that initiated events resulting in death) LAST Cardiomyopathy Due to (or as a consequence of):	Approximata interval Between Onset and Death
Cause. Entar UNDERFUND CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceu	months
PART II. Other significant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER OF DEATH 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 YES 2 NO 286. DLATE OF INJURY N/A 286. DLATE OF INJURY N/A 286. PLACE OF INJURY N/A N/A 286. PLACE OF INJURY	months
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	In Part I, 24s, WAS AN AUTOPSY 24b, WERE AUTOPSY PINDINGS
2 Accident Investigation N/A M 1 YES 2 NO 28. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Ni City or Town, State) 29e. CERTIFIER Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as attend. 29b. SIGNATURE AND TIFLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month 30692 May 5, 19	PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE
2 Accident Investigation A M 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route No City or Town, State) 282. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 283. LOCATION (Street and Number or Rural Route No City or Town, State) 284. LOCATION (Street and Number or Rural Route No City or Town, State) 285. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. PLACE OF INJURY — At home, farm, street, fectory, office 281. LOCATION (Street and Number or Rural Route No City or Town, State) 286. LOCATION (Street and Number or Rural Route No City or Town, State) 287. LOCATION (Street and Number or Rural Route No City or Town, State) 288. LOCATION (Street and Number or Rural Route No City or Town, State) 289. LOCATION (Street and Number or Rural Route No City or Town, State) 289. LOCATION (Street and Number or Rural Route No City or Town, State) 289. LOCATION (Street and Number or Rural Route No City or Town, State) 289. LOCATION (Street and	
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3 Suicide 6 Could not be determined 286. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route No. City or Town, State) 286. PLACE OF INJURY — At home, farm, street, factory, office 287. LOCATION (Street and Number or Rural Route No. City or Town, State) 288. PLACE OF INJURY — At home, farm, street, factory, office 288. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATION (Street and Number or Rural Route No. City or Town, State) 289. LOCATIO	28d, DESCRIBE HOW INJURY OCCURED
290. LICENSE NUMBER 30692 290. LICENSE NUMBER 30692 May 5, 19	
296. LICENSE NUMBER 30692 296. LICENSE NUMBER 30692 May 5, 19	we to the cause(e) and menner as stated. the time, data and piece, and due to the cause(e) end menner as stated.
The state of the s	DATE SIGNED (Month, Day, Year) May 5, 1995
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	305, Rockville, MD 20850
MAY 08 1995 Julia Davidson Roydall	DHMH-18 Rev 1/89

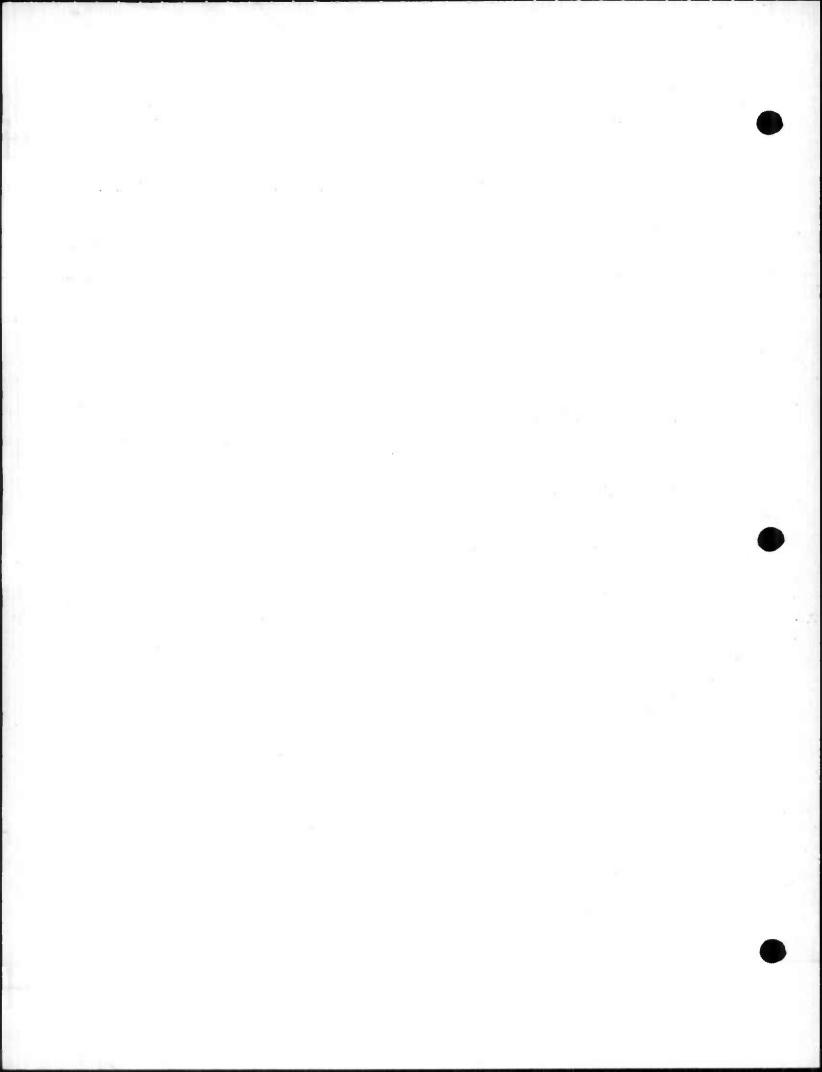


DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAN			CHIL	ICALL	E UF	DEAL	П	F	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DAY	Y	YEAR	3. TIME OF DEATH
	Clayton R.		man, S						May	8,]	995		9:30 a м
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la		IF UNDER	1 YEAR	IF UNDER 2	MIN.	7. DATE OF I	BIRTH V. Year)		6. BIRTI Count	HPLACE (State or Foreign
	579-56-0686	<u>XX</u> M 2 □ F	51	YAS.					Feb.	27,1	944	W	ash. DC
E	96. FACILITY NAME (If not institution, give str 4113 Post Gate	e Terra	ce				ver S					ONTO	GOMERY
5	RESIDENCE OF DECEDENT							-					
DIRECTOR	10s. STATE 10b. COUNTY			1	Y, TOWN								10d. INSIDE CITY LIMITS?
	Maryland Mor	ntgomer	У		Sil	ver	Spri	ing					1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?
則	4113 Post Gate						20	906				U.S	S.A.
2	11. MARITAL STATUS 1 ☐ Never Merried 2 ★ Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF	RMED NO	13.	WAS DEC	ENDENT OF	HISPAN	C ORIGIN? (S	pecify Yes	or No—	14. RACI	E — American Indian, k, Whits, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE W					2 □₩0			.,,			my: Black
	15. DECEDENT'S EDUC (Specify only highest grade of		16s. Di	ECEDENT'S	USUAL O	CCUPATIO	ON .		16b. KIN	D OF BUS	INESS/INI	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5		. Do NOT us	se retired.)	auring mo	st of working	,					
MP	9th			Un	emp.	Love	ed				Non	е	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							ER'S NAM	AE (First, Middl	e, Maiden S	Sumame)		
BE	Unknown							kno					
0	19s. INFORMANT'S NAME (Type/Print)		19						oute Number, C				20906
	Clayton Colema	n, Jr.	(Son)	41	L3 P	ost	_Gat	e T	er.,	Sil	ver	Spr	ing, MD
- 4	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Remo	val from State	20b. PLACE carpetery, cre	AND DATE (DE DISPOS	ITION /A/a	me of		DATE	200 100	ATION	Othe or To	nun State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		Metr	opo.	lita	n C	rema	tor	y5/9	Ale	exar	ndri	a, VA
ı	TOMAS I	Z A	UMM	100	S	MOM		FUN	ERAL	HOM	Ε, Ε	P.A.	
-	23. PART I. Enter the diseases, or co	-,0	Pu via	un	R	OCK	VILL	Ε,	MD 2	0850)		
- 1	shock, or heart fellure. L	let Dniy Dne ceu	se Dn each line	eath. UD n D.	ot enter	tha mo	de of dyln	g, auch	aa cardlac	or reapir	atory an	reat,	Approximate interval Between
	iMMEDIATE CAUSE (Finel disease or condition	Back	/										Onset and Death
	resulting in death)	Back	MAI	pn	eu	m	00	la					Lagrys
_		HIA	(On AS A COMSE	COENCE OF	-):								200-
<u></u>	Sequentially list conditions, if any, leading to immediate	DUE TO.	OR AS A CONSE	OUENCE OF									ox years
CERTIFICATION	cause. Enter UNDERLYING	HIV	Info	ck	OL	า							1549m
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	OUENCE OF	F):								107111
	resulting in death) LAST												
- 11	PART II. Other aignificent conditions	contribution to	double but not	eneral de la colonia	n Alba aun	al a al a la a							
EDICAL	Anoma : Keye								Part I. 24e	PERFORM		246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
	Pro ba ble how	Oliver Sp	aga	11-0					10	YES 2	NO		OF DEATH?
Σ	the state of the s	halle of the facilities	The Late Assessment	The state of the s	-	-	nos		_	ŕ			1 YES 2 NO
Ž	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CA	CONTRACTOR CONTRACTOR	TH YE		40 D	UNCE	RTAIN					
PHYSICIAN:	EXAMINER?	HOSPITAL:		Т	OTHER								
<u>~</u>	27. MANNER OF DEATH	1 Inpetient 2 I			4 🗆 Nun		\rightarrow		Other (Sp				
	1 Netural 5 Pending	(Month, De		26b. TIMI	URY	and a	RK7		26d. DESCRIE	BE HOW IN	JURY OC	CURED	
à l	2 Accident investigation 3 Suicide 6 Could and be	284 PLACE O	F INJURY — At ho	me form			YES 2 NO						
	4 Homicide 6 Could not be determined	building,	atc. (Specify)	, , , , , , ,	nreet, tech	ory, orner			City or To	wn, Stete)	id Number	or Humil F	Number,
OMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of	my knowledge, de	eth occurre	d at the ti	me, data	and place, a	ind due t	o the causele	and men	ar as atal	ad	
	one) 2 MEDICAL EXAMINER												snd menner as stated.
ŭ	29b. SIGNATURE AND TITLE OF CERTIFIER					1	29c. LICEN						(Month. Day, Ybar)
מ ו	talialing was	dno	uu.	M.X			7	-00	16				
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS		М 27) (Туре,	Print)			~ 0	60		14	ay.	2000
	KATHARINE	WA	CD41	7 NA	1	D.	20	00	Denni	s Ae	y. S	Sirs	a Mo
	31. DATE FILED (MANY) US 1991	32. REGISTRA	AUCLION A	and II									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to have been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

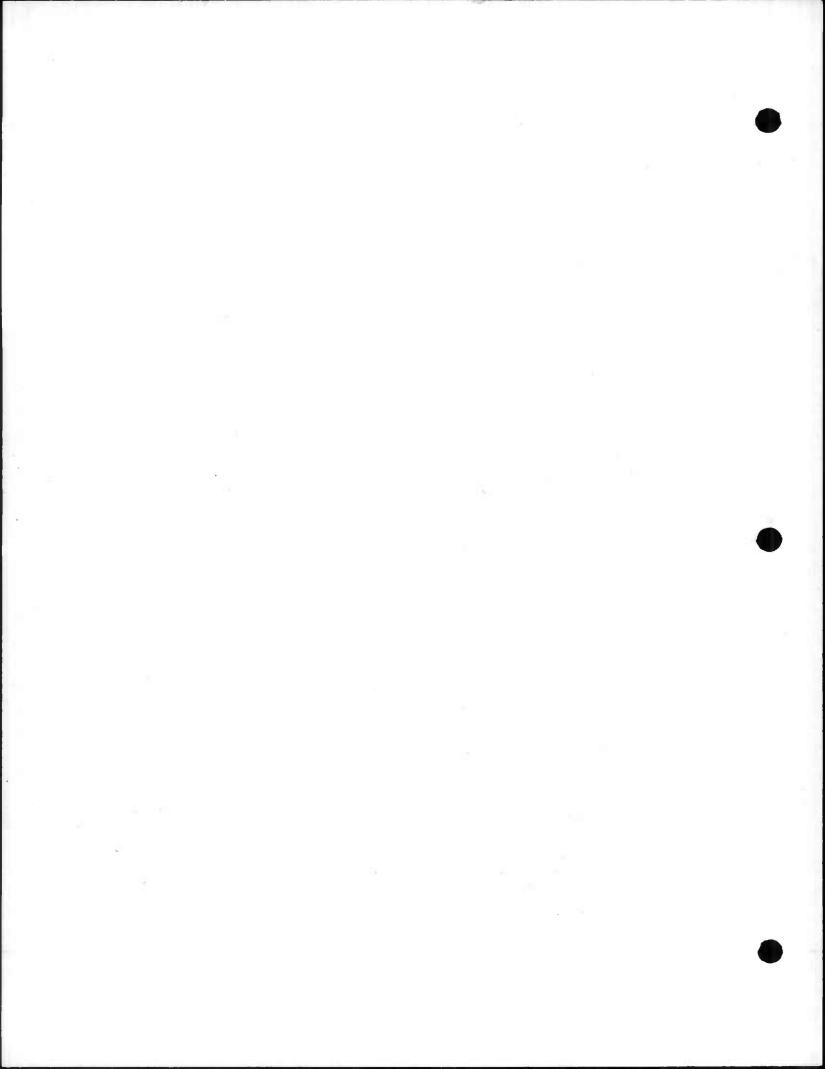
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_				7 IN 11 11 11 11 11 11 11 11 11 11 11 11 11	IVAI	LUI	DEAL			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE OF MONTH	DEATH	Y	YEAR	3. TIME OF DEATH
		Karla Va							May 7		95		12:56 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UND	ER 1 YEAR	IF UNDER 2	24 HRS. MIN.	7. DATE OF (Month, D			8. BIRTHP Country	LACE (State or Foreign
	563-59-6918	1 🗆 M 2 🔀 F	28	YRS.					May 7		7		aragua
or I	9e. FACILITY NAME (If not institution, give s				9b. CIT	TY, TOWN	OR LOCATIO	N OF DE	EATH		9c. COU	NTY OF DE	HTA
DIRECTOR	Suburban Hospi	tal				Beth	esda				Mor	ntgom	ery
E E	10e. STATE 10b. COUNTY	,		10c. CIT	Y. TOWN	OR LOCA	ITION					T	10d. INSIDE CITY
띩	Virginia Prin	ce Willia	a m										LIMITS?
	10e. STREET AND NUMBER	ice willie	anı		100a	brid	ge H. ZIP CODE				40 - 017		1 YES 2 X NO
FUNERAL	12616 Kempston	Tano				1							
Z	11. MARITAL STATUS	12. WAS DECEDENT	FUED IN LIG	- DIFF	1		2219						states
	1 Never Married 2 Married	FORCES? 1	YES 2 2	NO	13	If yes, s	pecify Cuben.	. Mexica	VIC ORIGIN? (S in, Puerto Rici	in. etc.)	or No-	14. RACE Bleck,	— American Indian, White, etc.
B	3 Wildowed 4 Divorced	IF YES, GIVE W	AR OR DATES			1 🔼 YE	s 2 🗆 no N	ica:	raguan	1		Specify	White
요	15. DECEDENT'S EDUC		16a, I	DECEDENT'S	USUAL	OCCUPATI	ION			ND OF BUS	INFRC/INF	MISTRY	MILLE
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of vite. Do NOT us	vork done e retired.	during m	ost of working	7	100. 10	NO OF BOS	IIVE 33/IIV	JOSTRI	
٦	Elements y Saconomy (0-12)	5+		roject	- As	sist	ant		Wo	rld I	anle		
8	17. FATHER'S NAME (First, Middle, Last)			- , - 0	- 110			FR'S NA	ME (First, Mide			-	
	Carlos David	Vargas							et Ter		surriente)		
	19e. INFORMANT'S NAME (Type/Print)	vargas		ION MAILINO	ADDRES	ee /Pronet			Route Number,		On the Wi	0.61	
2	Andrew S. Cabana												00100
	20e. METHOD OF DISPOSITION									-			a 22192
	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, o	rematory or of on all N	ther place 1 emo	rial	May Park	10,	1995			city or Tow hurch	n, State , Virginia
- 1	21, SIGNATURE OF FUNERAL SERVICE LIC	ENGEE		400046	R.C	ber	ND APPRES	S CENT	hrey I	Euner	al H	ome/E	Sethesda- Avenue
	W/what	, HURL	m	400846	Be	ethe	sda, M	láry	land	2081	4-35	01	Avenue
	23. PART I. Enter the diseases, or c	omplications that	caused the c	death. Do n	ot ente	r the mo	ode of dyln	g, sucl	h aa cardlad	or respli	story ar	reat,	Approximate
Į	shock, or heart failure. I	List only one duds	se on aach IIr	na.									Interval Between Onset and Death
	disease or condition	Mult	iple Tr	auma									Acute
ľ	resulting in death)	·	OR AS A CONS		P):								110000
_													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF	j:								+
3	cause. Enter UNDERLYING												1
	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONS	EQUENCE OF	7):								
=	resulting in death) LAST	1.											į
	DATE II OAL I - MI A MI												
EDICAL	PART II. Other significant conditions	s contributing to d	death but not	resulting i	n the u	ındariyin	g cause gi	ven in	Part I. 24	e. WAS AN A			WAILABLE PRIOR TO
5									1	YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
Ĕ													YES 2 NO
	DID TOBACCO USE CONTR	RIBUTE TO CAL	JSE OF DE	ATH YE	S 🗆	NO P	9 UNCE	RTAIN	1 🗆				
5 1	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL/	CE OF DEAT	-)						
2	1 X YES 2 NO	HOSPITAL: 1 ☐ Inpatient 2X	ER/Outpatient	3 🗆 DOA	OTHE 4 Nu		ne 5 🗆 Resi	idence	8 Other (S)	pecify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF I (Month, De)		28b. TIMI	E OF	28c. IN.	JURY AT		28d. DESCRI		JURY OC	CURED	
	1 Natural 5 Pending Investigation	May 7,		I INJ	M		YES 2 X	NO	Left	Turn	Hi+	on H	er Side
5 II	3 Suicide 6 Could not be	28e. PLACE OF	INJURY — At P	iome, farm, s	treet, fac	ctory, offic	:0		284 LOCATIO	M /Ctmat a	and Alexandra	no Oceant Co.	de Manhae
<u> </u>	4 Homicide determined	building, e	itc. (Specify)	St	ree	+			Cai+h	own, State)	oshe	n + M	Midcounty
4 1	290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of n	ny knowleder				Ulidopera		Gaith				Lanu
COMPLETE	(Check only one) 2 MEDICAL EXAMINER												and manages are stated
				Contractigation	n, ni my	opinion, c				piace, end	dus to th	e cause(s)	end menner as stated.
u l	296. SIGNATURE AND TITLE OF CENTIFIER	7/1	111	CH	X	2	29c, LICEN	ISE NUM	IBER				Wonth, Day, Year)
5	Accelle	ung			000	\sim	D709	99			Ma	ay 7,	1995
- 1	30. NAME AND ADDRESS OF PERSON WHO												
	Francis C. Mayle,	M.D., 10	215 Fe	rnwoo	d Re	oad.	Bethe	esda	Mar	vland	20	817-1	106
	MAY 11 1995	32. HEGISTRAR	'S SIGNATURE	. 1 11							7.1.		
	MAI 11 1995	Julia du	martin, M	wall									

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



ded#1, 101(GF) GF, Montgomery Co.

® BALTIMORE, MARYLAND 21215-0020

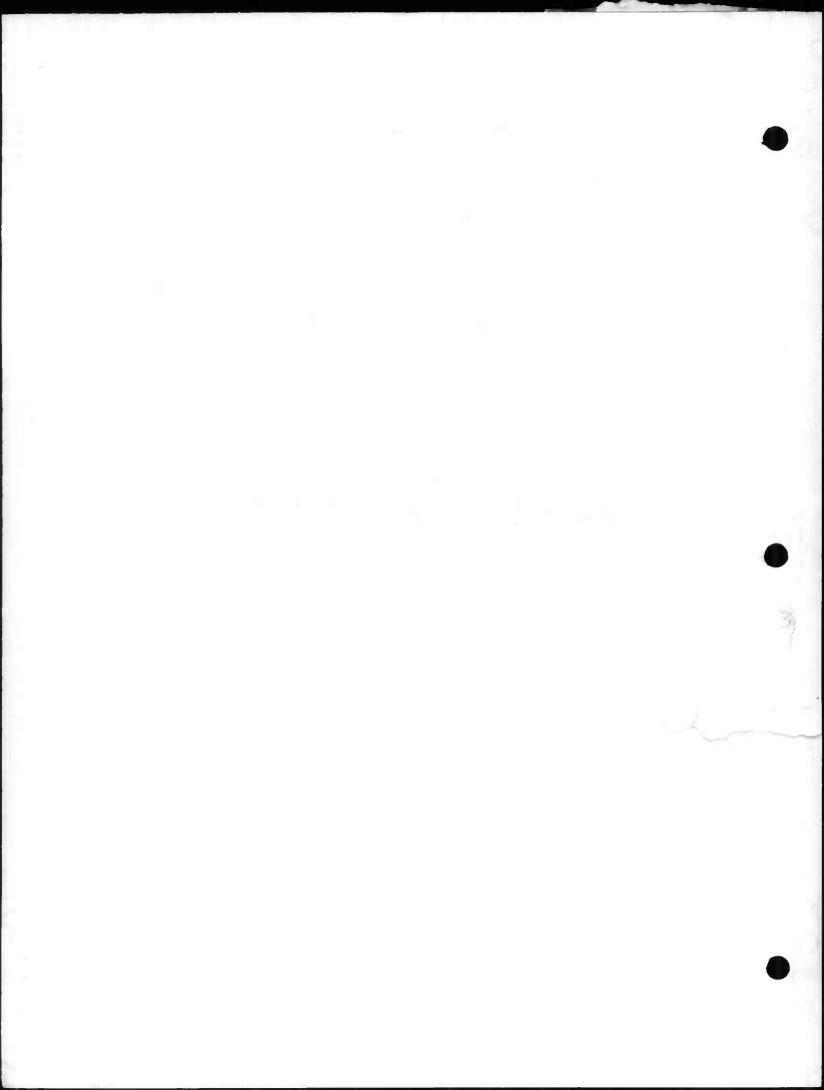
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	FOR 1 - STATE REGISTRAR	01 (64)	STATE OF I	MARYLAN	ND / DEPA					MENT	AL HYGIEN			
100	1. DECEDENT'S NAME (First,	ŝ	CON	NELL		LLIA				MO	TE OF DEATH	AY	YEAR	3. TIME OF DEATH 5:30 A M
	4. SOCIAL SECURITY NUMB		5. SEX		yrs. lest birthde) IF UNDE	DAYS	# UNDE	R 24 HRS.	7. DAT	TE OF BIRTH onth, Day, Year)		Count	
	9a. FACILITY NAME (If not in	slitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCAT	ION OF DI		b. 25,1	V	MIC NTY OF E	higan
DIRECTOR	Collingswood		sing Cen	ter				kvi1						gomery
REC	10a. STATE	10b. COUNTY	,	-	10c. C	ITY, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
	Maryland	Mo	ontgomer	Y			Roc	kvil	le					1 🔀 YES 2 🗌 NO
3AL	10e. STREET AND NUMBER						10	r. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	199 Rollins	Avenue						208					ted	States
BY FU	11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V 1949-19	YES WAR OR DATE	2 NO	13.	II yes, sp	ENDENT (ecify Cubi 2 NO	en, Mexica	n, Puerl	GIN? (Specify Yes o Rican, etc.)	or No-	14. RACI Blac Spec	E — American Indian, k, Whita, etc. thy: White
9	15. DEC	EDENT'S EDUC	CATION	-	Sa. DECEDENT	'S USUAL C	CCUPATION	DN		1	6b. KIND OF BUS	SINESS/INI	DUSTRY	WIIICE
	(Specify only Elementary/Secondary (0	highest grade	College (1-4 or 5	+)	(Give kind o	f work done use retired.)	during mo	st of worki	ng					
AP.	12		_		Photo	graph	er				Mil	itar	У	
COMPLETED	17. FATHER'S NAME (First, Mi							18. MOT	HER'S NA	ME (Firs	t, Middle, Maiden	Sumame)		
BE			ael Conne	elly					De	1ia	Mary Y	eske		
5	19a, INFORMANT'S NAME (7)										mber, City or Tow			
	Mary Leonard								Contract of the Contract of th	_	en,Mass	achu	sett	s 02418
	20a, METHOD OF DISPOSITI 2 Burlal 2 Crematio 4 Donation 5 Other	(Specify)		206. PL cemete Ar I	ry. cremetory of						Ar1	_	on,	Virginia
- 5	21. SIGNATURE OF FUNERAL	Le G	ENSEE Huu	70 N	100348	H	ome/	Rock	vill	e,	Inc., 3	A. P 00 W 850-	. Mo	rey Funeral ntgomery Ave
CERTIFICATION	23. PART I. Enter the di ahock, or he immediate CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to immediate. Enter UNDERLY! CAUSE (Disease or injuithat initiated events resulting in death) LAST	one, fiete	DUE TO	OR AS A CO	CONSEQUENCE	ori uar	,	1 Ce				ratory an	reat,	Approximate interval Between Onset and Death Wh. 2 yns.
PHYSICIAN: MEDICAL CE	PART II. Other algnifices	nt condition	s contributing to	deeth but	not resulting	in the u	nderlyin	g cause	given in	Part I.	24s. WAS AN PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
IAI	25. WAS CASE REFERRED TO	MEDICAL					26, PI	ACE OF D	EATH (Ch	ock only	one)			
SIC	1 YES 2 NO		HOSPITAL:	ER/Outpatie	ent 3 🗆 DOA	OTHE	Pr.				her (Specify)			
É	27. MANNER OF DEATH		26a. DATE OF (Month, D		28b. T		28c. INJ				ESCRIBE HOW II	NJURY OC	CURED	
ВУ		Pending nvestigation	(1101,01,0	uy, 1027		M		/ES 2 [□ NO					
ED	3 Suicide 8 0	Could not be letermined	28a. PLACE O building,	F INJURY — atc. (Specify)	At home, farm	, street, fac	tory, offic			281. LC	CATION (Street a by or Town, State)	and Number	or Rural I	Route Number,
COMPLET			CIAN: To the beat of e) and menner as stated.
Ö	29b. SIGNATURE AND TITLE								ENSE NUN					(Month, Day, Year)
0	98	9		2	0			D	41	93	/	DA	100	8 1995
2	25 huc	PERSON WHO	MD 9	SE OF OEATH	Med med	p. Print)	Dr	#	310	No	ckv.	1/0	M	D 20850
	31. DATE FILED (Month, Day,	2 1995	32. REGISTRA	R'S SIGNATU	Rarball						-/	, ,	<u> </u>	00

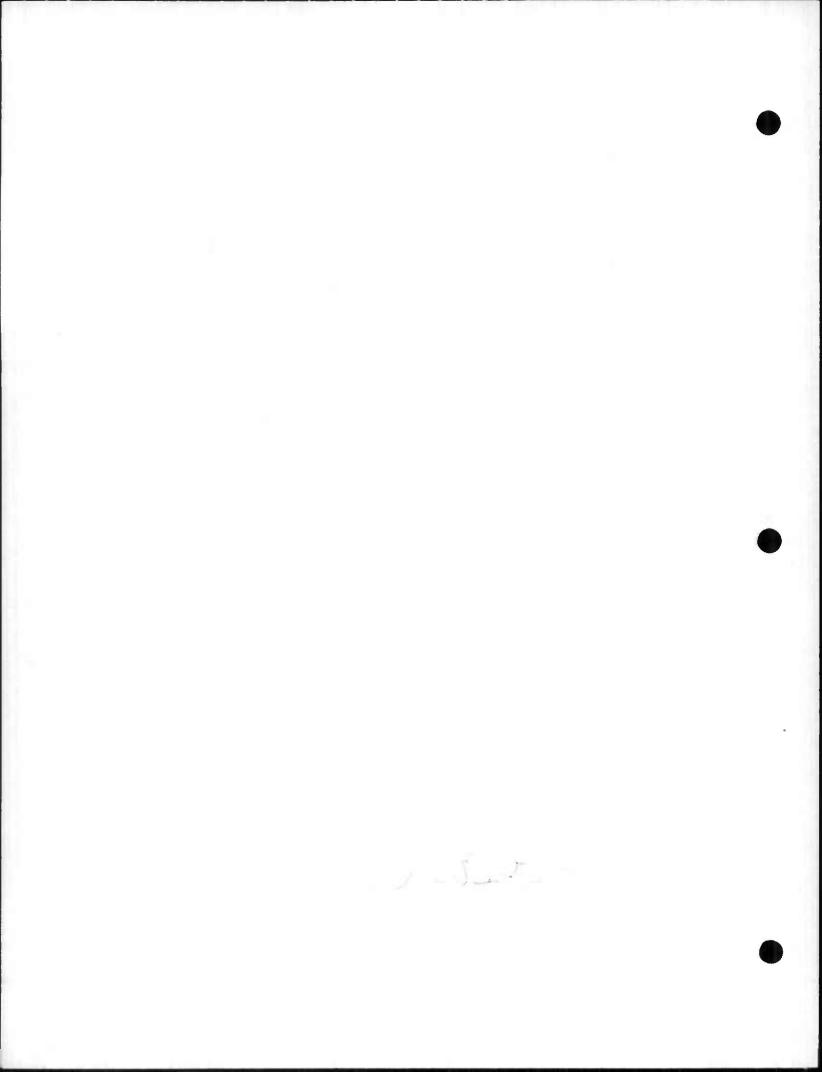


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the blospital on the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

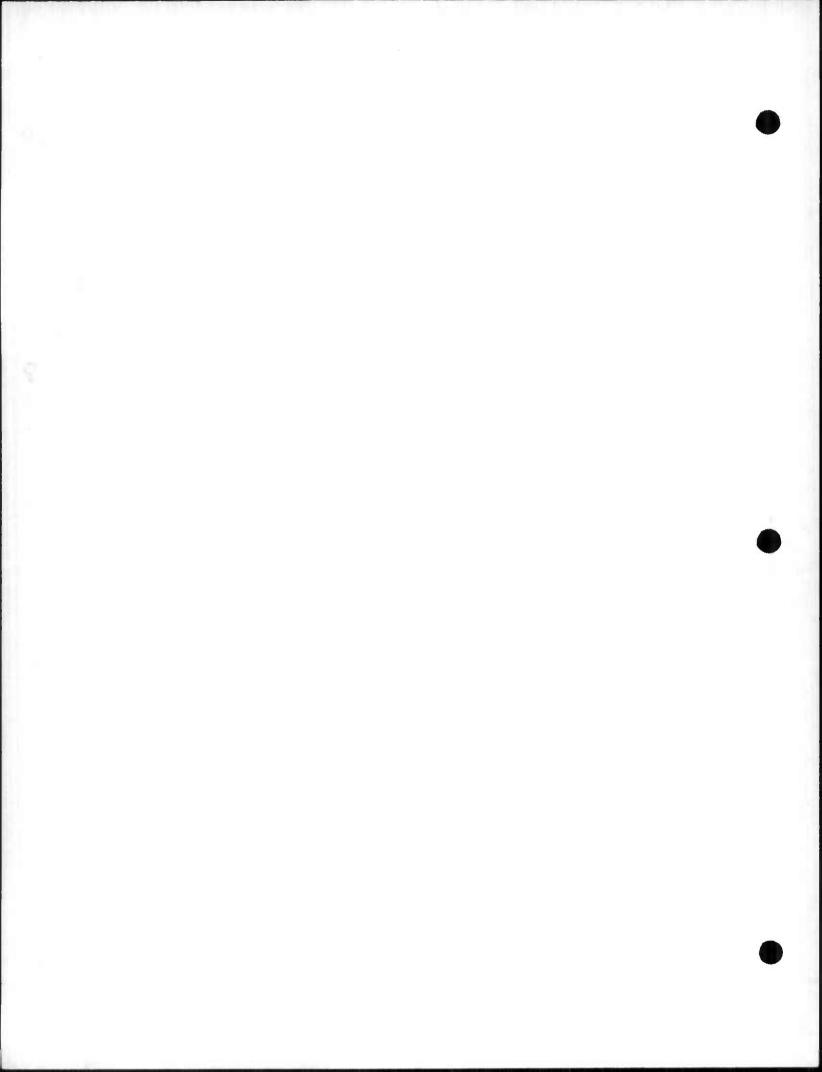
					7711 01	DEMIII	MEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA		CASH				2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER						MAY 9,	1	995	4:05 P M
		5. SEX	6. AGE (In yrs. las		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTHP Country)	LACE (State or Foreign
	579-28-8578	1 🗆 M 2 💢 F	69	YRS.	OHTHS UMTS	HOUNG MIN.	May 8, 19	26		h Carolina
	9e. FACILITY NAME (If not institution, give st	reet and number)		9	b. CITY, TOWN	OR LOCATION OF O			NTY OF DE	
2	St. Mary's Hospit	-al		- 1	Leonar	dtown		C+	Manu	l o
1 8	RESIDENCE OF DECEDENT	POT			renigt	ULUWII		St.	Mary	S
l m	10e. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOCA	TION				10d, INSIDE CITY
DIRECTOR	Maryland Prince	e George	's	Hyatt	sville					LIMITS?
4	10e. STREET AND NUMBER	53			10	H. ZIP CODE		10g. CITI	IZEN OF WI	HAT COUNTRY?
FUNERAL	5305 Chesapeake F	Road				20781		Uni	ted	States
15	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MEO	13. WAS DE	CENDENT OF NISPA	NIC ORIGIN? (Specify Yes		14. RACE -	- American Indian,
	1 Never Married 2 Married	IF YES, OIVE V	YES 2X N	10		pecify Cuben, Mexico S 2X NO Specia	en, Puerto Rican, etc.)			White, atc.
BY	3 X Widowed 4 Divorced					o M Speci	η.		Specify	White
	15. DECEDENT'S EQUO		16a. DE	CEDENT'S US	SUAL OCCUPATI	ION	18b. KIND OF BUS	INESS/INC	JUSTRY	1111200
	(Specify only highest grade Elementary/Secondary (0-12)		1/20	ive kind of wor. Do NOT use r	k done during m	ost of working				
1 7	8	College (1-4 or 5		usewi1	-		O - Ho	200		
COMPL	17. FATHER'S NAME (First, Middle, Last)		ПО	OSEMTI	LE		Own Hor			
examiner must be notified at once. TO BE COM						1577	ME (First, Middle, Maiden			
B B	Thomas	51.	lls			Mamie		K	Kille	brew
\$	19e. INFORMANT'S NAME (Type/Print)		190	. MAILINO A	OORESS (Street	end Number or Rural	Route Number, City or Town	, Stata, Zip	Code)	
5	John A. Minnick	(Son)	1	909 De	ennis A	ve. Silv	er Spring,	MD	20902	2
2	20a. METHOD OF DISPOSITION				DISPOSITION /N				City or Town	o State
200	1 Burial 2 X Cremation 3 Remo	rval from State	cemetery, crei	matory or other	r place)					
6	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGER /	unesa	<u>peake</u>	Cremat	ory	5-11 Bel	<u>tsv1</u>	TIE,	MD
퉅	THE STATE OF THE SERVICE ELO	57			Rann	NO ACCRESS OF FA	Services, I	Δ		
EX3	2 MK		MOO	927			Silver Spi		MD	20040
2	23. PART I. Enter the diseases, or c	ometications the	t caused the de	eth Do not	JJJJ G	ist Ave,	STIAGE Shi	ering,	שמ	20910
medical	shock, or heart fallure. I	lat only one cau	se on each line	. Do not	antar trie mi	oda or dying, auc	n as cardiac or reapi	ratory arr	eat,	Approximate interval Between
9	IMMEDIATE CAUSE (Final									Onset and Death
=	disease or condition resulting in death)	Intra	cerebral	hemor	rhage					Hours
ş			(OR AS A CONSEC							110013
9 7										
ows any injury, or other traumatic event, the AEDICAL CERTIFICATION	Sequentially list conditions,	OUE TO	(OR AS A CONSEC	UENCE OF):						1
AT	if any, leading to immediate cause. Enter UNDERLYING			Service Con-						į i
티유	CAUSE (Disease or injury	OUE TO	(OR AS A CONSEC	HENCE OF						
티트	that initiated events resulting in death) LAST	002.10	(OIL AS A CONSEC	ochoc orj.						
9 1										
5 0	PART II. Other algorificant conditions	contributing to	death but not a	enulting in t	the underlyin	a course alves la	Dart I as unnau		Tan a	1
FDICAL		continuoting to	Geath Dot not 1	aaviting in	ine unuariyin	ıg cause given in	Part I. 24s. WAS AN . PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
# N							1 _ YES 2	ON D		COMPLETION OF CAUSE OF DEATH?
S W										YES 2X NO
š 2	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YES	TI NO F	LINCERTAI	N D			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				(Check only one)					
y Item	EXAMINER?	HOSPITAL:		_ 0	THER:					
5 5	1 TYES 2X NO	1 X Inpetient 2				ne 5 🗆 Residence	8 Other (Specify)			
is marked, D BY PH	27. MANNER OF DEATH	28a. DATE OF (Month, D		28b. TIME O		JURY AT ORK?	28d. OEŞCRIBE HOW IN	JURY OCC	CURED	
BY BY	1 X Netural 5 Pending 2 Accident Investigation				M 1 🗆	YES 2 NO				
2 O	3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At hor	me, ferm, stre	et, factory, offic	e	281. LOCATION (Street e	nd Number	or Rural Roi	ute Number,
COMPLETED	4 Nomicide determined	building,	etc. (Specify)				City or Town, Stete)			
E W	29e. CERTIFIER									
	(Check only									
<u></u>	2 MEDICAL EXAMINER	: On the bests of e	mination end/or in	nveatigation, i	in my opinion, o	death occured at the	time, date end piece, and	due to th	e ceuse(s) (end manner es stated.
	29b. SIGNATURE AND TITLE OF CERT	1	à 1			29c. LICENSE NUI				
BE		100	1/4/							Month, Day, Year)
<u>₽</u>	20 NAME AND ADDRESS CO.			1		D 07212		Ma	ay 10	, 1995
	30. NAME AND ADDRESS OF PERSON WHO		SE OF DEATH (ITEN	4 27) (Type, Pri						
	Nayan R. Shah, M.				P.0	. Box 66	4, Leonard	town.	MD	20650
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	A						
	MAY 12 1995	Julia di	audion Ran	dall						



6

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE O				3. TIME OF DEATH
			Samuel	David	Claye	3				May	10.		YEAR	5:30 A M
	4. SOCIAL SECURITY NUME		5. SEX	B. AGE (In yrs	s. lest birthday)	IF UNDE		IF UNDER		7. DATE OF			8. BIRTI	HPLACE (State or Foreign
	310-52-4333		1 X M 2 🗆 F	56	YRS.	MONTHS	DAYS	HOURS	MIN.	May	1, 19	339	Sie	rra Leone
m	9s. FACILITY NAME (If not in		street and number)					OR LOCATI		EATH			NTY OF D	
DIRECTOR	5001 Odell	Road				Be	elts	/ille				Pri	nce	George's
) E	10a. STATE	10b. COUNT	Υ		10c. CI1	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
	Maryland	Prin	ce George	e's		Belts	svil	le						LIMITS?
\¥	10e. STREET AND NUMBER						110	. ZIP COD				10g. CIT	IZEN OF	WNAT COUNTRY?
FUNERAL		y Hil	1 Court					2070						States
	11. MARITAL STATUS 1 Never Married 2	Merried	12. WAS DECEDEN	YES 2	NO		If you, sp	ecify Cubi	ın, Mexica	IIC ORIGIN?		or No-		E — American Indian, k, Whits, etc.
ВУ	3 Widowed 4 XXDIvo	roed	IF YES, GIVE Y	MAR OR DATES			1 TYES	2 [X NO	Specify	y:			Spec	My: Black
COMPLETED	15. DEC (Specify only	EDENT'S EDU	CATION completed)	16a	(Give kind of life. Do NOT u	USUAL O	CCUPATIO	ON ost of working	na	16b. K	IND OF BU	SINESS/IN		1007
<u>_</u>	Elementary/Secondary (0	-12)	College (1-4 or 5											60
ME	17. FATHER'S NAME (First, M	iddle Leet)	4	Ac	dminist	rat:	Lve (Sierr	ra Leone
	William B.		VP						iscil	ME (First, Mid	essel			30
BE	19s. INFORMANT'S NAME (7		, 0		19b. MAILING	ADDRES	S (Street a						Code)	
2	Priscilla	Claye			Same								,	
	20a. METHOD OF DISPOSIT 1 ☐ Buriel 2 Crematic	ION n 3 🗆 Rem	novel from State	20b. PLA	CE AND DATE	OF DISPOS	SITION (NE	ama of		DATE		CATION		
	4 ☐ Donation 6 ☐ Other 21. SIGNATURE OF FUNERA	(Specify)		_ Cr	r, cremetory or d 1esapea					5-18	Belt	tsvil	le,	Maryland
	()	M X	. /)				EUDEI		our Servic	es. I	D. A.		
		, ,	1 2 / 3	PP		93	33 G:	ist A	Avenu	Je, Si	lver	Spri	na.	MD 20910
	23. PART J. Enter the di ahock, or h	seesea, or seert failure.	complications the List only one cas	at caused the	death. Do	not entar	tha mo	de of dy	ing, auch	h aa cardla	c or reapl	ratory an	rent,	Approximata interval Between
	IMMEDIATE CAUSE (Fir disease or condition	al	C MAN	200 - 700										Onset and Death
	reaulting in death)	→	Inanii	COR AS A COR	MEGUIENAE A	-								1 month
_				tatic (,	of I	una						6 months
CERTIFICATION	Sequentially list conditi if any, leading to imme-			(OR AS A CON			JL L	uriy						O IIIOTTETIS
2	CAUSE (Disease or inju		c											
E	that initiated eventa reaulting in death) LAS	Т	DUE TO	(OR AS A CON	NSEOUENCE O	F):								
빙			d											
AL	PART II. Other aignifica	nt condition	na contributing to	death but n	ot resulting	In the ur	ndarlyin	g cause (given in i	Part I. 2	4a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL										_ 1	YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?
- I	DID TOD 1650 11						_							1 TYES 2 TY NO
AN	DID TOBACCO U		KIBUTE TO CA		LACE OF DEA			JUNC	ERTAIN	1 🗆 📗				
PHYSICIAN:	EXAMINER? 1 YES 2 NO	J MEDICILE	HOSPITAL:			OTHE	R:			- cV		2		
H	27. MANNER OF DEATH		28s. DATE OF	INJURY	26b. TIM	E OF	28c. INJ	URY AT	eldence	6 DOTHER (S				Home
ВУ Р		Pending Investigation	(Month, E	Nay, Year)	IN.	IURY M		PRK?] NO					
								Route Number,						
	4 Homicide determined City or lown, Stelle)													
APL	29s. CERTIFIER (Check only one) 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piecs, and due to the cause(s) and manner es stated.													
SO	3 Suicide 4 Homicide 5 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, Erm, afreet, Sectory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29c. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or Investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									s) and manner as stated.				
BE	29b. SIGNATURE AND TITLE	OF CENTIFIE	-11		0	,			ENSE NUM					(Month, Day, Year)
0	30. NAME AND ADDRESS OF	PERSON WIL	O COMPLETED CALL	SE DE DEATH	OTEM 270 G	Endant's		D 4	4336	1		1	May .	10, 1995
	Robert Sie			L50 Per			Ava	nue	MM	Most	inct	20 5	00 0	20027
	020	, 11					O V E	4 h pour		WHE	If IT /	17.1		
	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	AR'S SIGNATUR	NE O	111120	71101	100,	1400 3	Wasi	ringe	JII, L	2	.0037

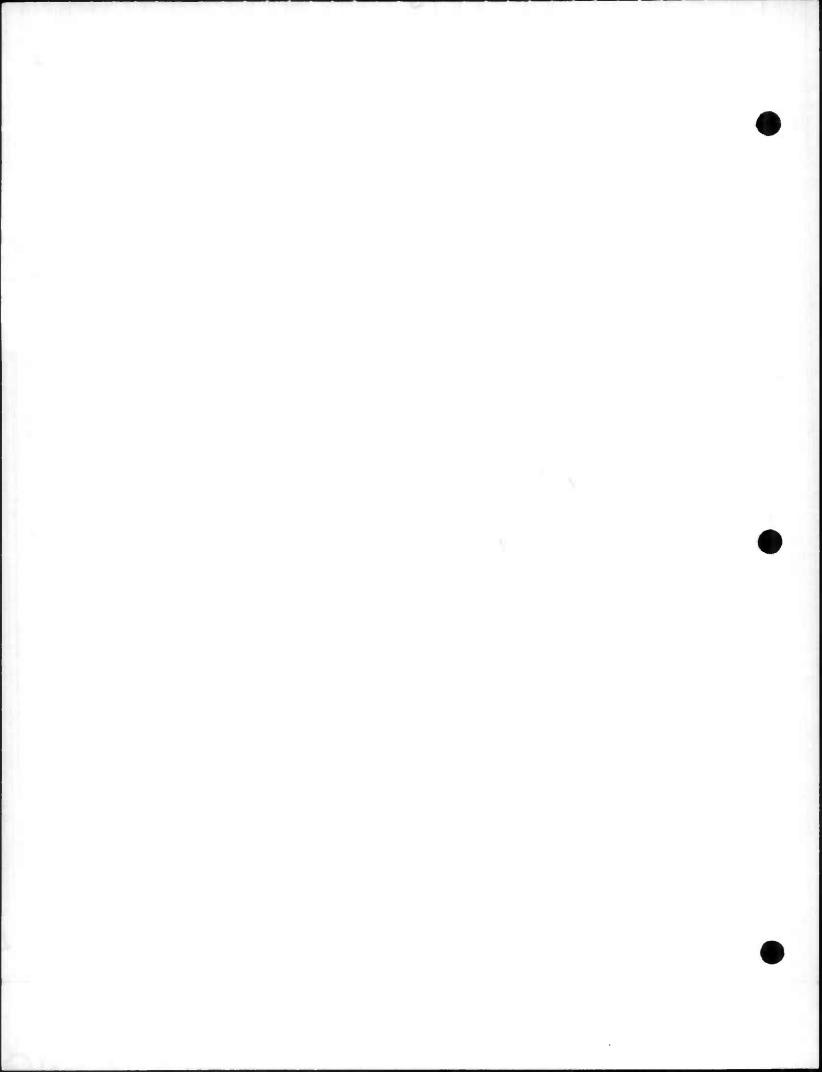


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within the State Deat of Health and Memai Hydiane prior in burial cremation or removal BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

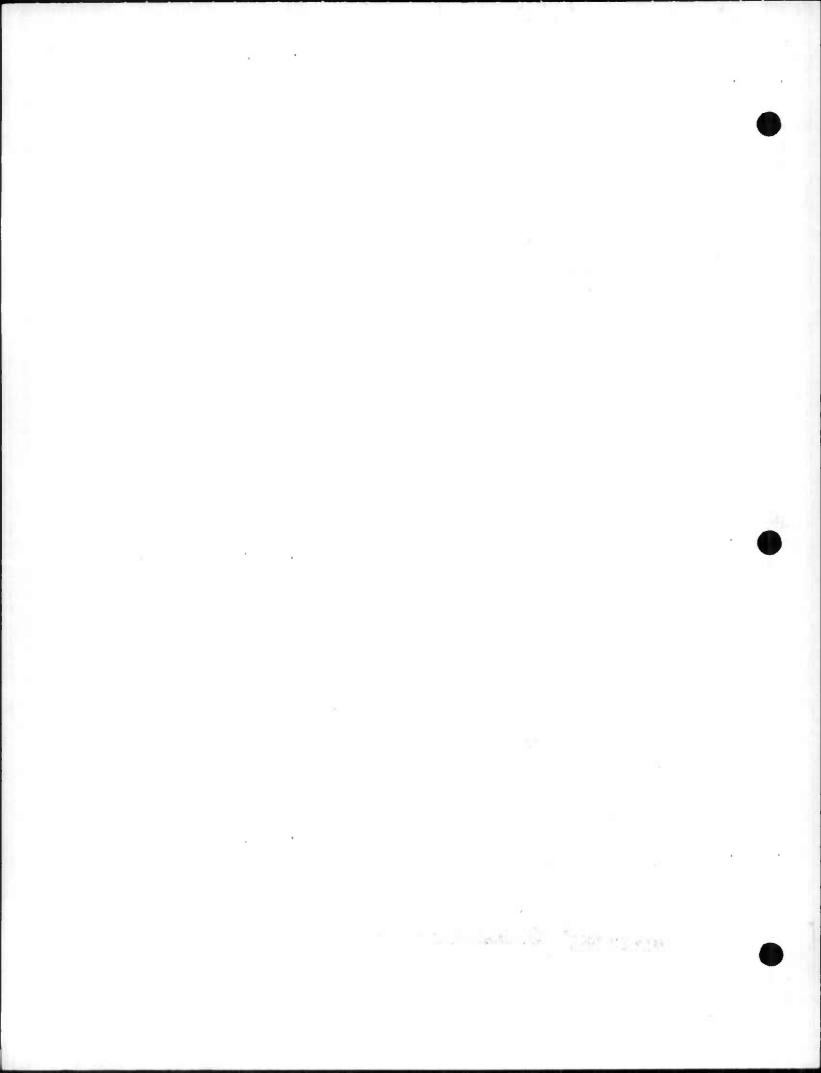
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. OECEDENT'S NAME (First	, Middle, Last)							-	2. DATE OF DEATH			3. TIME OF DEATH	
		PETER G. C.	HIPOUR	AS							May 11	AY 1	995	11:00 Am	
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER		-	1 24 HRS.	7. DATE OF BIRTH		6. BIRTH	HPLACE (State or Foreign	
		578-12-424		1 💢 M 2 🗌 F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept. 15,	1903	Gre	ece	
		9a. FACILITY NAME (If not in					9b. CITY,	TOWN	OR LOCAT	ION OF DE			INTY OF D		
	6	1801 Greenp		errace			Roc	ckvi	11e			Mon	tgom	ery	
	DIRECTOR	10a. STATE	10b. COUNT	1		10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY	
- 1	Ha	Maryland	Prince	Georges	3	Gle	enn D	ale						LIMITS?	
	AL.	10e. STREET AND NUMBER						_	. ZIP COD	E		10g. CIT	TIZEN OF V	WHAT COUNTRY?	
	FUNERAL	_11408 Daise	y Lane	<u> </u>					2076	59			USA	110	
ı	2	11. MARITAL STATUS 1 Never Married 2	aireall.	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. V	WAS DEC	ENDENT	OF NISPAN	IIC ORIGIN? (Specify Yer	or No-	14. RACI	E — American Indian, k. White, etc.	
	B	3 Nidowed 4 Divo		IF YES, GIVE V						Specify		44	Spec		
	ETED	15. DEC (Specify only	EDENT'S EDU y highest grade	CATION completed)		DECEDENT'S (Give kind of	work done d	CUPATIO	ON ast of worki	ng	16b. KIND OF BU	SINESS/INI	DUSTRY		
- 1	7	Elementary/Secondary (0)-12)	College (1-4 or 5	۰) "	ife. Do NOT u	very	Drei			Constant	- n:-	0		
Jee.	COMPL	17. FATHER'S NAME (First, M	liddle Last)	0		Dell	lvery	DI		445@10 MA	Crusty		Con	npany	
at once.	EC	George Chip									a Merekou.				
notified	00	19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADORESS	(Street a			Route Number, City or Tow		p Code)		
10u	임	Rev. Basil	Kissal											land 20850	
traumatic event, the medical examiner must be		20e. METHOD OF DISPOSITI	n 3 🗆 Ram	oval from State	20b. PLACE	E AND DATE	of Disposi	TION (Na	meof		5 / 1 6 Rror	CATION -	City or To	own, Stata	
19	- 1	Fort Lincoln Cemetery 5/16 Brentwood, Man													
exam		22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904													
9		Silver Spring, Maryland 20904 23. PART I. Enter the discesses, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate													
E B	- 1	snock, or neert fellure. List only one ceuse on eech line.												Interval Setween Onset and Death	
f,		A CONTRACTOR OF THE CONTRACTOR												neonths	
eve	Ì	DUE TO (OR AS A CONSEQUENCE OF): (GENECI'S CICCHOSI'S Vears													
natic	CERTIFICATION	Sequentially list conditions, If any, leading to immediate b. CCANECY CITTHOSIS DUE TO (OR AS A CONSEQUENCE OF):												years	
trau	AT	If any, leading to immediate cause. Enter UNDERLYING												ľ	
other	Ĕ	CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):													
0		resulting in death) LAST													
injury,		PART II. Other significa	nt condition	s contributing to	death but not	reculting	In the unc	derlying	Ceuse	alven in	Part I. 24s, WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS	
any i	DICAL			_							PERFOR	MED?	7	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
SWO	MED										1 YES 2	LIMO		OF DEATH?	
	- 1	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆 N	10 🗔	UNC	ERTAIN	10			· [] res 2 [] NO	
Item 2	CIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSBITAL	28. PL/	ACE OF OEA		,							
- Jo	XSI	1 TYES 2 THO		HOSPITAL:	ER/Outpetient	3 🗆 DOA	OTHER		5 7 R	sidence	6 Other (Specify)				
marked,	27. MANNER O DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2								RK7] NO	26d. DESCRIBE NOW I	NJURY OC	CURED		
00		2 Accident Investigation 3 Suicide 6 Could not be detarmined													
29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and menner as															
									a) and menner as stated.						
IMPORTANT: II	TO BE	296. SHISHKTUNE AND TITLE	alul		AM	dg/1	no			27		29d, DAT	E SIGNED	(Montp, Day, Year)	
		30. NAME AND ADDRESS OF		Sles 1	OF DEATH (IT	NO C	Print)	nw.	aye	Tr.	Dr. Gre.	enbe	1+10	Md 20790	
		31. DATE FILEO (Month, Day,	2 199!	July d	R'S SIGNATURE REVELLER R	ardall			1						



	1. DECEDENT'S NAME (First, I	Middle Lest)			CERT	IFICAL	_ 01	DEA		REG. NO				
		widowa, zwaty							1	DATE OF DEATH	AY	YEAR 3.	TIME OF DEATH	
	JAMES 4. SOCIAL SECURITY NUMBER	E	5. SEX	0.000.0	CRAI					AY 02,19			:41 P	
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	205-26-3920		Λ	6	1 YR					Mar.14,1	934 L	anca	ster, PA	
~	9e. FACILITY NAME (If not inst		,			11.0			ON OF DEAT	N	9c. COUNT	Y OF DEAT	гн	
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ក្ត	RESIDENCE OF DECI	10b. COUNTY			1							UZINO		
DIRE	PA		ancaster			CITY, TOWN		HON				10	Id. INSIDE CITY	
		ь.	ancaster			ancasi	er.					1	YES 2 NO	
FUNERAL	10a. STREET AND NUMBER						101	. ZIP CODI	E		10g. CITIZE	N OF WHA	T COUNTRY?	
	1734 Crool	ked Oa	k Dr.					17	601		U.S.	Α.		
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1			13.	WAS DEC	ENDENT C	F HISPANIC	ORIGIN? (Specify Ye		4. RACE -	American Indian,	
	1 Never Married 2 1 Nover 1 Nover Married 2 1 Nover 1		IF YES, GIVE V						Specify:	Puerto Rican, etc.)		Specify:	thite, etc.	
BY	3 Widowed 4 Divorc	ped						X				Whi	te	
ETED	15. DECE (Specify only	OENT'S EDUCA	ATION completed)		18e. DECEDEN	T'S USUAL C	CCUPATIO	ON of of working	200	16b. KIND OF BU	SINESS/INDU	STRY		
<u>u</u>	Elementery/Secondary (0-1		College (1-4 or 5	+)	life. Do NO	T use retired.)	outing inc	or or works	*					
COMPLE	12				Labor	Liaso	on			Marketi	na Co	mnoni	.Co.	
ō I	17. FATHER'S NAME (First, Mid	idle, Last)						18. MOTI	HER'S NAME	(First, Middle, Meiden	Surneme)	mharry		
W	Jacob Arley	v Crau	n					Do	rothy	Frye				
0	19e. INFORMANT'S NAME (Typ.				19b. MAIL	ING ADDRES	S (Street a			te Number, City or Tow	n State Zin C	iorie)		
일	Nancy L. Cr	ralin								Lancaste			1	
	20e. METHOO OF DISPOSITIO			1 200					л.,					
	1 Duriel 2 Cremation	3 Remov	val from State	ceme	PLACE AND OA etery, crematory	or other place.					CATION CI			
	4 Donation 8 □ Other (S	-	NOCE	- Mi	llersy					5/6/95 M	illers	vill	e,PA 17	
- 1	Lal a			t ,		22.	NAME AP	O ADDRES	SS OF FACIL		F. Gr	off.	Inc.	
	Fred F. Groff, Inc. 234 W. Orange St., Lancaster, PA 17603 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, interval Return													
z	iMMEDIATE CAUSE (Fine disease or condition resulting in death)	+ .	Seps DUE TO DUE TO	ded	CONSEQUENCE	perito	nea	1 he	mato	ma-			48hr	
ERTIFICATIO	Sequentisity list condition if any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury that initiated events resulting in death) LAST	late IG y c.	OUE TO	(OR AS A	CONSEQUENCE	E OF):								
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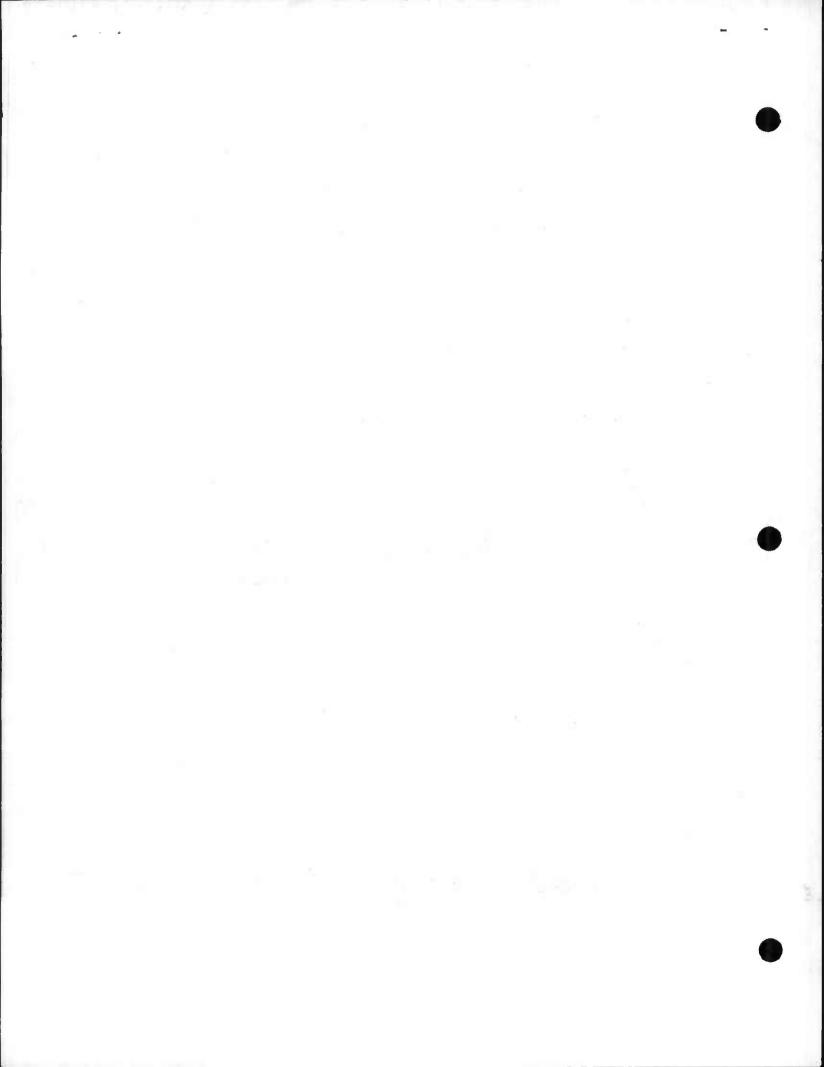
BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 78 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H			HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	DEATH		3.	TIME OF DEATN	
1	Thor	mas Reynolds	Carpent	er		Мау	11. 1	995 YE		10:30 F	M C
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF	BIRTH	0.0	HOTTHIN A	CE (Class or Form	
	220-32-9197		79 YRS.	MONTHS DAYS	HOURS MIN.	Aug	12, 16ar) 1	915	Ma	ryland	
~	9a. FACILITY NAME (If not institution, give			96. CITY, TOWN C	R LOCATION OF D	EATN		9c. COUNTY			
0	4215 Hoopers Nec	k Road		Taylor	s Island			Dorch	nest	er	
EC	100. STATE 10b. COUN	TY	10c. CITY,	TOWH OR LOCAT	ION				100	I. INSIDE CITY	
DIRECTOR	Maryland I	Oorchester	T	aylors :	Island				1,1	LIMITS?	
	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZEN			
FUNERAL	4215 Hoopers Nec	k Road			21669			J	JS		274
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF NISPAI	NIC ORIGIN?	Specify Yes	or No 14.	RACE Black, W	American Indian	,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2XXNO Specif		en, etc.)		Specify:	White	
	15. DECEDENT'S ED	UCATION	16a. DECEDENT'S U	SUAL OCCUPATIO	10.1	405. 10					
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	Se completed) College (1-4 or 5+)	(Give kind of wo	rk done during mo.	st of working	16b, K	IND OF BUS	INESS/INDUST	RY		
7	12	College (1-4 of 5+)	Farmer				Pou1t	ry Ind	lust	rv	
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Mid			ius c.	<u>. y</u>	
BE	Allan Carpen	iter			Edit	h Lan	nbdin				
0	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural						
-	Patsy T. Carpent		P.O.	Box 38	Taylors	Islar	id, Ma	aryland	210	669	
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Rea	moval from State 20b.	PLACE AND DATE OF	DISPOSITION (Na er place)	me of	DATE		ATION - City			
	4 Donation 5 Other (Specify)	S S	alisbury			5/12	Sa]	lisbury	, Ma	aryland	
	All OHERSE SERVICE D	CENSEE			o address of fa		16				
	the will the	72		700 1	Locust S	t. Cam	bride		ylaı	nd 2161	3
	23. PARY I. Enter the diseases, or shock, or heart failure	complications that caused. List only one cause on as	the death. Do no	t entar the mo	da of dyling, suc	h sa cardia	c or reapir	atory srrest,		Approximate	
	IMMEDIATE CAUSE (Final			. (0				j	Onset and I	
	disease or condition resulting in death)	· Mya	adul	Myo	rufco	21				mound	2
		DUE TO (OR)AS A	CONSEQUENCE OF):	4.4		,					
CERTIFICATION	Sequentially list conditions,	b	CONSEQUENCE OF:	m /	nase					UND	
PAT	if sny, leading to immediate cause. Enter UNDERLYING		U						ĺ	0	
Ĕ	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):								
	resulting in desth) LAST	d									
	PART II. Other significant condition	na contributing to death bu	it not resulting in	the underlying	cause given in	Part t 2	In. WAS AN A	UTOREV	245 WE	RE AUTOPSY FING	WALCO .
S				and analyting	occoo given in		PERFORM	WED?	AVA	ILABLE PRIOR TO WPLETION OF CAL	
						— ¹	YES 2	D/NO	DF	OEATH?	
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	F DFATH YES	U NO E	UNCERTAII	<u> </u>			1 (YES 2 NO	
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL		IN PLACE OF DEATN		OTTOLICIAL						
Sign	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpa		OTHER:	5 Residence	6 D Other (S	ipecify)				
Ě	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJU	JRY AT			JURY OCCURE	D		
BY	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO						
	3 Suicide 6 Could not be	26a. PLACE OF INJURY - building, etc. (Special	— At home, term, str	et, factory, office		281, LOCATI	ON (Street en fown, State)	nd Number or Ru	iral Route	Number,	
	4 Nomicide determined						,				
7		SICIAN: To the best of my knowle									
COMPLETED	2 MEDICAL EXAMIN	ER: On the basis of examination	end/or investigation,	in my opinion, de	eth occured at the	time, date an	d place, and	due to the cau	ree(s) and	f manner ee stat	ed.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R NOI	-0		29c. LICENSE NUM	MBER		29d. DATE SIG	NED (Mo	nth, Day, Year)	
TO B	Vulle	117 h	1		1)02	173		D 3/1	2/9	S	
-	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEA	-oul		793	2/10	1/-	- 11	7. A	01/	1
	31. DATE FILEO (Month, Dey, Year)	L 176		4)	2001	SKEN	15/	CW	my	Public 1	Luf
	MAY 1 5 1995	Jalia d'autisex	Mardallo			C ·					

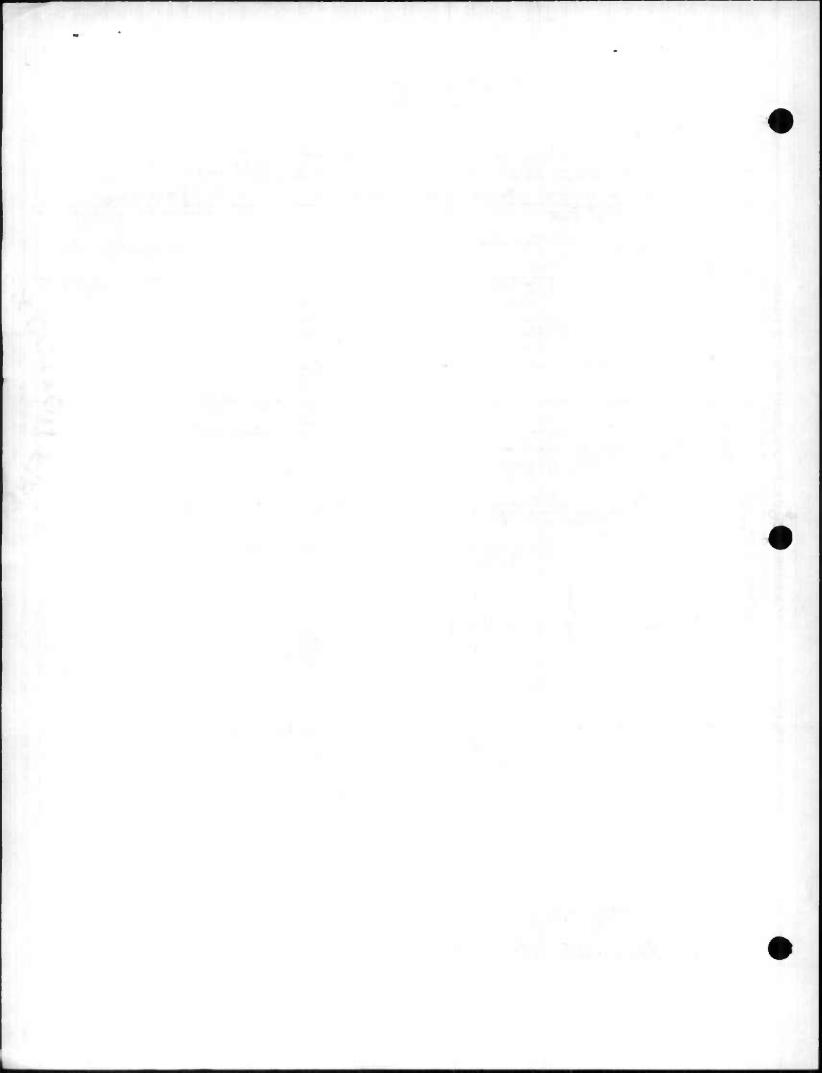


BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 17 burns after death within 12 burial-transit permit. Pages 1, 2, 3 should be filled within 17 burns after death within 12 burns. Pages 1, 2, 3 should be filled within 17 burns after death within 12 burns and the page 1, 2, 3 should be filled to 12 burns after death within 12 burns and the page 1, 2, 3 should be filled to 12 burns after death within 12 burns and the page 1, 2, 3 should be filled to 12 burns and 12 burns after a burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns and 12 burns after 20 burns after 20 burns after 20 burns after 20 burns after 20 burns and 12 burns after 20 burns after 20 burns after 20 burns and 12 burns after 20 burns after DIVISION OF VITAL RECORDS, P.O. BOX 68760,

K

	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPART			MENTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	MARY E. CAHOON 4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	05 1	.0 95	4:45 PM
	214-10-0882 Se. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 F	86 YRS.	ONTHE DAYS	HOURS MIN.	(Month, Day, Year) March 07,	1909 M	aryland
DIRECTOR	Mallard Bay Nurs			Cambrid	ge,	EATH	Dorches	
EC	10a. STATE 10b. COUNT	ТҮ	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland	Dorchester		Cambri	dge			LIMITS?
₹	10s. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF V	
Ä	520 Glenburn A				21613		US	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2XXINO	If yes, spe	ENDENT OF HISPA Helfy Cuban, Mexico 200 NO Specifi	NfC ORIGIN? (Specify Yes an, Puerto Rican, atc.) y:	Black	- American Indian, k, White, atc.
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad		16a. DECEDENT'S US	SUAL OCCUPATION done during mos		16b. KIND OF BUS	SINESS/INDUSTRY	
Ē	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	Iffe. Do NOT use	retired.)	n or worning			
₹ P	10		Hom	emaker				
	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden		14
B B	Peter Kennedy 19a. INFORMANT'S NAME (Type/Print)		Emiliario management			tha Tina		
2	Bettie H. Bramb	1e				Aoute Number, City or Town Cambridge,		21612
8	20a. METHOD OF DISPOSITION		b. PLACE AND DATE OF				CATION City or To	
	1 Buriel 2 Cremation 3 Rer	noval from State	metery, crematory or othe Wicomico M	plece)	Dark			Maryland
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	WICOMICO II		D ADDRESS OF FA		illsbuly,	rial y Lallu
	> Khut The	m			s Funera			
	23. PART I. Enter the disesses, or		ed the death. Do not	anter the mod	OCUST SI	t. Cambride	retory street	Approximate
	shock, or heart failure. IMMEDIATE CAUSE (Final	. List only one cause on	aach line.				intoly entest,	Interval Between Onset and Death
	disesse or condition	. Arterio-so	aleratic C	ardiom	amilam T)		
	resulting in death)		A CONSEQUENCE OF):	arurova	SCUIAL L	rsease		Years
Z		b						
DIT.	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):					
	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE TO (OR 40	4 0000000000000000000000000000000000000					
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):					
CEL		d						
AL	PART II. Other algnificant condition	na contributing to deeth	but not resulting in	the underlying	ceuse given in	Part i. 24s. WAS AN PERFOR	AUTOPSY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	Alzheimers Dise	ease, Congest	ive Heart	Failur	e (contro	olled) 1 - YES 2	NO NO	COMPLETION OF CAUSE OF DEATH?
ME								1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL							
S	EXAMINER?	HOSPITAL:		THER:	ACE OF DEATH (Ch			
5 ×	27. MANNER OF DEATH	1X Inpatient 2 ER/Out 28e. DATE OF INJURY	28b, TIME (6 Other (Specify) 28d. DESCRIBE HOW II	N INDV OCCUPED	
	1 Natural 5 Pending	(Month, Day, Year)	MJUF	Y WO	RK? ES 2 NO		NOTE OF THE PROPERTY OF THE PR	
BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJUR	Y — At home, ferm, stre			281. LOCATION (Street a	and Number or Rural F	loute Number,
TE	4 Homicide determined	building, etc. (Spe	ecity)			City or Town, State)		
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	wledge, death occurred	at the time, data	and place, and due	In the cause(s) and man	mer as stated	
. S	enel .	ER: On the basis of examination) and manner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI		29d. DATE SIGNED	22 200 11 200 11
BE		6 6 mil	uau C	mD	D14349		D 51	11195
2	30. NAME AND AGORESS OF PERSON WI	HO COMPLETED CAUSE OF D						7.0
	Eyup Tanman ,M.1). 15 Frankli	in St. Cam	bridge,	Marylan	nd 21613		
	31. DATE FILEO (Month, Day, Year)	32 REGISTRAR'S SIGN	NATURE		-			
	MAY 1 5 1995	falsa d'aucles	r Nardall					



DIVISION OF VITAL RECORDS, P.O. BOX 13146, ABALTIMORE, MARYLAND 21203-3146 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death on TO THE FUNERAL DIRECTION. After this certificate has been signed by the attend be filed within 72 hours after death with the State Dept. of Health and Mental Hy IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or

	certificate be executed within. Turs after death. Page 6 may be retained by the hospital or attending physician.	and completely fined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
	oital	of b		
	hos	tache		000
	the	e de		4
	P	d bi		-
	etaine	shou		other transactio amont the medical avancians must be notified at some
	pe r	1ge 5		40
	may	or. pe		900
	9 96	lirecto		100
	Pa .	eral d		Ania
	death	P.		BAGA
0	after	y the	TOVA	100
X.	SIN	=	r re	post
		Pined	Ju.	9
	Jin.	tely	matic	#
•	Wild	mple	Crei	Nan
	cuted	8	unial,	He a
	9000	in an	tygiene prior to burial, cremation, or removal.	1000.00
	te b	Sicia	prior	-
	tifical	I phy	ene	Shar
	cen	ding	Ž	10

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Y YEAR	3. TIME OF DEATH
	MASON	LEE	CUTI		R.	May 6.	1995	7:45 AM
		X M 2 □ F	78. MO	HTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/9/19	41 Coun	Maryland
TOR	4204 Graceton I		91		ylesvi		9c. COUNTY OF Hai	rford
DIRECTOR	10s. STATE 10b. COUNTY	arford	10c. CITY, T	OWN OR LOCATI		esville		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER	eton Road	a	10f.	ZIP CODE	0	10g. CITIZEN OF	WHAT COUNTRY?
BY FUNE		. WAS DECEDENT EVER IN FORCES? 1 YES	U.S.ARMED 2 A NO		cify Cuben, Mexica	NIC ORIGIN? (Specify Yearin, Puerto Rican, etc.)	Bla	CE — American Indian, ck, White, etc.
COMPLETED		ON spleted) ollege (1-4 or 5+)	Ilfe. Do NOT use re	k done during mos stired.)	t of working		SINESS/INDUSTRY	
MP	8 17. FATHER'S NAME (First, Middle, Last)		Mason (jontra		ME (First, Middle, Maiden	Jonstr	letion
		ason Cu	tlip			Mabel	Sumame)	Rudd
BE	19a. INFORMANT'S NAME (Type/Print)	20012		ODRESS (Street ar		Route Number, City or Tow	n, State, Zip Code)	Ituuu
2	Annette M. Cut	lip	\$	same a	s #10			
	20 METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal 4 Donation 6 Other (Specify)	from State 20b.	PLACE OF DISPOSITION OTHER PLACE OF DISPOSITION OF THE PLACE OF THE PL	Mem.	Garden	s 5/9 Fa	cation – city or llston.	Town, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS	les Kun	ho			cuty Funeral tsville.		and
	23. PART I. Entar tha diseases, or com ahock, or heart fallure. List	plications that caused only one cause on ea	the death. Do not on line.	enter the mod	de of dying, auc	h as cardiec or reap	ratory arreat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)		TO CE	LLU-L.	AR	CARC	Nomi	Onset and Death
TION	Sequentially list conditions, if any, leading to immediate	`	CONSEQUENCE OF):					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
	PART II. Other algnificant conditions c	ontributing to death bu	it not resulting in	the underlying	cause given in	Part I. 24s. WAS AN	ALITOPSY 24	No. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL						PERFOR	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ä								
S		OSPITAL:		THER:	ACE OF DEATH (C)			
H	27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME C	OF 28c, INJI	JRY AT	6 ☐ Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	M 1 V				
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, stc. (Special	— At home, farm, atre	eet, factory, office	1	281. LOCATION (Street City or Town, State)		l Route Number,
COMPLET	mont only	N: To the best of my knowle						e(a) and manner as stated.
BE CC	290. BIONATURE AND TITLE OF CERTIFIER	1	ny		29c. LICENSE NU	MBER	29d. DATE SIGNI	ED (Month, Day, Year)
5	30, NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, PI	rim) MI	Can 82	ZAIR	COAS	(And)
	31. DATE FILED (Month, Day, Year) MAY 1 2 1995	32 REGISTRAR'S SIGNA	Radall	/	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 10	6	7047

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of the second

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

Amended # 5/00,232, M. B. S. Allegany Co.

Amended # 106,5/12/95, M. S. S. Allegany Co.

1. FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	REGISTRAR			ENTIR	ICALE	· Ur	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	_	~		_			2. DATE O	F DEATH DA	AY	YEAR	3. TIME OF DEATH
	Charles	D.	Cooling					Ma	1 10	2	95	1600 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER 24 HRS.	7. DATE 9	F BIRTH		8. BIRT Coun	HPLACE (State or Foreign
	220-10-0289	1.XXM 2 □ F	75	YRS.	MONTHS	DAYS	HOURS MIN.	7. DATE 9 (Month), Jan.	25,	1920	Ma	ryland
	9e. FACILITY NAME (If not institution, give st	reet and number)	-		9b. CITY,	TOWN C	OR LOCATION OF D			9c. COL	INTY OF	
Œ.	Union Hospital				F	1kt	on			Co	cil	County
K	RESIDENCE OF DECEDENT					,110				00	CLL	Country
M	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY
5	Maryland Cec	1 County	7		hesa	nea.	Ake City					LIMITS?
إ	10e. STREET AND NUMBER					-	. ZIP CODE			10a CI7	IZEN OF	WHAT COUNTRY?
A.	104 3rd St.					1000	21915					WILLI COURTER
FUNERAL DIRECTOR	11, MARITAL STATUS										SA	
3	1 Never Merried 2XXMerried	12. WAS DECEDEN FORCES? 1	XXYES 2	RMED NO	13. \	MAS DEC 1 yes, sp	ENDENT OF HISPAI	NIC ORIGIN? en, Puerto Ri	(Specify Yes	or No-	14, RAC Black	CE — Americen Indien, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1	YES	2 XIO Specif	fy:			Spe	White
		World										willte
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(0	CEDENT'S live kind of v	vork done o	CUPATIO	ON st of working	16b. I	CIND OF BU	SINESS/IN	DUSTRY	4.0
۳.	Elementery/Secondary (0-12)	College (1-4 or 5 d	-)	. Do NOT us	,							
₽	12	4	K	eeble	er Co	oki	e Co.		Bakin	g.		
Θļ	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First, Mi	ddle, Maiden	Sumeme)		
BE (Gilbert C. C	cooling					F1	ora		Maz1	in	!
	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street e	and Number or Rural	Route Numbe	r, City or Tow	n, Stete, Zi	p Code)	
2	Thelma Cooling			104 3	3rd S	t.	Chesape	ake C	itv M	arvla	and	21915
- 1	20a. METHOD OF DISPOSITION		20b. PLACE					OATE		_		own, State
- i	1 Buriel 2x Cremation 3 Remo	oval from State	cometery co	amatory or o	ther nlevel			1			•	
	21. SIGNATURE OF FUNERAL SERVICE LIC	FNSPE	- I Cullib	eriai	IU CI	ema	tory May	11 9	ol cu	mber.	Land	, md.
	71/-	1	//		22.1		Boal Fun		Home			
	" Wayne	400	XX.		1	11 (Church S	t W	ester	naori	t M	d. 21562
	23. PART I. Entar the diseases, or c	omplications the	t causad the de	ath. Do n	ot antar	tha mo	da of dying, suc	h aa cardi	ac or reap	ratory ar	rest,	Approximate
	ahock, or haart fallura. I	List only one cad	on aach iin	2/2	10	\			SC. 100,000			Intarval Batween
	iMMEDIATE CAUSE (Final disease or condition	M	100		10	1	in	C v	1	1	0	Onset and Death
	resulting in death)	1117	(OR AS A CONSE	10	110	\sim	101	(a)	CT	10	1 1	Immeddiate
		Do	OH AS A CONSE	OUENCE OF	2. L.		C1.	oly		1 -	1	My 3 Days
CERTIFICATION	Sequentially list conditions,	· ros	2/06	Ols	777	C	Ca	OIY	CYS	160	_70	wy 3 Days
F	if any, leading to immediata cause. Enter UNDERLYING	£ 000 10	(UH AS A CURSE	OUENCE OF), (١.	LYC					1 D
5	CAUSE (Disease or injury	DIE TO	(OR AS A CONSE	OUTNOT OF	-0	- 11	rre					1 Day
Ē	that initiated eventa reaulting in daath) LAST	7	V CONSE	ODENCE OF):	$\backslash \mathcal{N}$						
H		ıY	M	+1			V					8 Years
	PART ii. Other aignificant conditions	s contributing to	death but not	rasuiting i	n tha un	derlyin	g causa giyan in	Part i.	24a. WAS AN	AUTOPSY	74	b. WERE AUTOPSY FINDINGS
EDICAL							3		PERFOR		"	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ā						_		- 1	1 TYES 2	NO		OF DEATH?
Σ	DID TODA CCO LICE C							\				1 TYES 2 NO
z	DID TOBACCO USE C	ONTRIBUTE	TO CAU	SE OF	DEAT	H Y	ES NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOERITAR .					ACE OF DEATH (Ch	neck only one				
Sic	1 TYES 2 THO	HOSPIFAL:	ER/Outpatient	□ DOA	OTHER		e 5 🗆 Residence	6 🗆 Other	(Specify)			,
£	27. MANNER OF DEATH	28e. DATE OF		26b. TIM		26c. INJ		28d. DESC	RIBE HOW I	NJURY OC	CURED	
	1 Natural 5 Pending	(Month, D	ay, 19ar)	INJ	URY M		PRK?					
BY	2 Accident Investigation 3 Suicide & Could get be	26e. PLACE O	F INJURY — At h	ome, ferm, a	street, lect			28f. LOCA	TION (Street)	and Numbe	or Rumi	Route Number,
<u>B</u>	4 Homicide 6 Could not be	building,	etc. (Specify)		,	,		City or	Town, State)	one (veringe	. 0. 110.0	Trodio Hambol,
Ψ.	29e. CERTIFIER											
4	(Check only											
COMPLET	one) 2 MEDICAL EXAMINE	R: On the beels of e	xamination end/or	Investigatio	n, in my o	pinion, d	eath occured at the	time, date e	nd place, en	d due to t	he ceuse	(s) and menner ee stated.
E C	296. SIGNATURE AND TITLE OF CERTIFIES	200	A A (1			29c. LICENSE NUI	мпея		29d. DA	TE SIGNE	0 (Month, Day, Year)
00	Ja: //	1//.	WIL				DUHT	111			1	10/95
2	30. NAME AND ADDRESS OF PERSON WHO	COMPCETED CAUS	SE OF DEATH STE	M 27) (Type	Print)	_	V-11	16			23/	0/12
I	1 Tim 1	no	3	111	111.	x/.	ust s	2. 1/	4	/	61	Kno mi
1	31. DATE FILED (Month, Day, Year)	30 DECISTRA	R'S SIGNATURE	///	w.0	Yey	unt o	Ruit	= 20	14	F/1	1011/10
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		1 - FOR STATE OF MARYLAND / CE		ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	:	
		1. DECEDENT'S NAME (First, Middle, Last) ZOILA B. CASTANON	V		2. DATE OF DEATH MONTH Y 14	95	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last $1 \square$ m 2XXF 6. AGE (In yrs. last 44	YRS. FU	NDER 1 YEAR IF UNDER 24 HRS. THS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) September 18,	1950 Gu	THPLACE (State or Foreign intry)
2, 3 should	стоя	96. FACILITY NAME (If not institution, give street and number) Route 50 and Thompson Creek Road	9b.	CITY, TOWN OR LOCATION OF DE Stevensville	ATH	9c. county of Queen	Anne 's
Pages 1,	DIRECT	RESIDENCE OF DECEDENT 10. STATE Florida Collier		WN OR LOCATION OKalee			10d, INSIDE CITY UMITS? 14 YES 2 NO
nsit permit.	ERAL	Post Office Box #1174		101. ZIP CODE 33934		10g. CITIZEN OF	F WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 Merried IF YES, GIVE WAR OR DATES	MED O	13. WAS DECENDENT OF HISPAN If yee, specify Cuban, Mexical XIX YES 2 NO Specify	n, Puerto Rican, atc.)	So	ACE — American Indian, ack, White, atc.
21 o e o	ETED	(Specify only highest grade completed) (Gir	CEDENT'S USUA ve kind of work d Do NOT use retin	lone during most of working	16b. KIND OF BUSI	-	
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Last)	grant w	18. MOTHER'S NAI	Farming ME (First, Middle, Maiden S		
MARYL retained by 5 should be notified at	O BE			Julian RESS (Street end Number or Rurel F			stanon
RE,		20e. METHOD OF DISPOSITION 20b. PLACE A		POSITION (Name of	DATE 20c. LOC	CATAN, G	Town, State
Page 6			er Fune	CIA CEMETERY 22. NAME AND ADDRESS OF FAI DONald V. Bor	19.1995 — Ta	numelra la	- Planida
s after by the emova	-	23. PART I. Enter the diseases, of complications that ceused the del	nth. Do not er	4400 Powder M	ill Rd. Bei	ltsvill	e, Md. 20705
ted within 2s hour completely filled in ial, cremation, or riseent, the mer		immediate Cause (Finel disease or condition resulting in death) a. Hemorrhagic Due to (or as a consco		cK			Intervel Between Onset and Death
X 68 X 68 In and to bur	MOIT	Sequentielly list conditions, if any, leading to immediate	UENCE OF):	facident,	Ejected	d	
P.O. B th certificat anding phy Hygiene p or other	CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST d.	UENCE OF):				
S, e dea whenta	- 11	PART II. Other significant conditions contributing to deeth but not re	esulting in the	e underlying cause given in	Part I. 24s. WAS AN A PERFORM		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
AL KECOKID I law requires that the has been signed by the Dept. of Health and 23 shows any in	MEDICAL				1 TYES 2	N/NO	OMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
4 2 - " EI	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE HOSPITAL:	E OF DEATH (Ch	neck only one)	1 🗆		
HYSICIAN: The HYSICIAN: The his certificate with the State certificate or item.	PHYSI	1	28b. TIME OF	HER: Nursing Home 5 Residence 28c. INJURY AT	6 Other (Specify) 26d. DESCRIBE HOW IN	JURY OCCURED	4
After the death v	B	1 Netural 5 Pending Investigation 3 Suicide 5 Could not be (Month, Day, Year) 1995	INJURY Ine, ferm, street,	M 1 YES 2 NO	Motor Ve 281. LOCATION (Street on	hicle t	tccident
DINISTED DE ATTEN DIRECTOR: hours after litem 28 i	LETED	4 Homickle determined	reet				son Creek Rd.
로 국 전 도	COMPL	(Check only one) CERTIFYING PHYSICIAN: To the beet of my knowledge, dear one) MEDICAL EXAMINER: On the beete of examination end/or in					e(s) end manner ee stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	290. SIGNATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WIFO COMPRETED CAUSE OF DEATH (ITEM		D 36	907	P MAY	ED (Month, Day, Year) 14 1995
		191. N. A. A. L.	hock Tr		hirerry of N	Tuny landy	Baltimore, MD
		MAY 2 5 1995 Julia di William Ran	dall				

nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

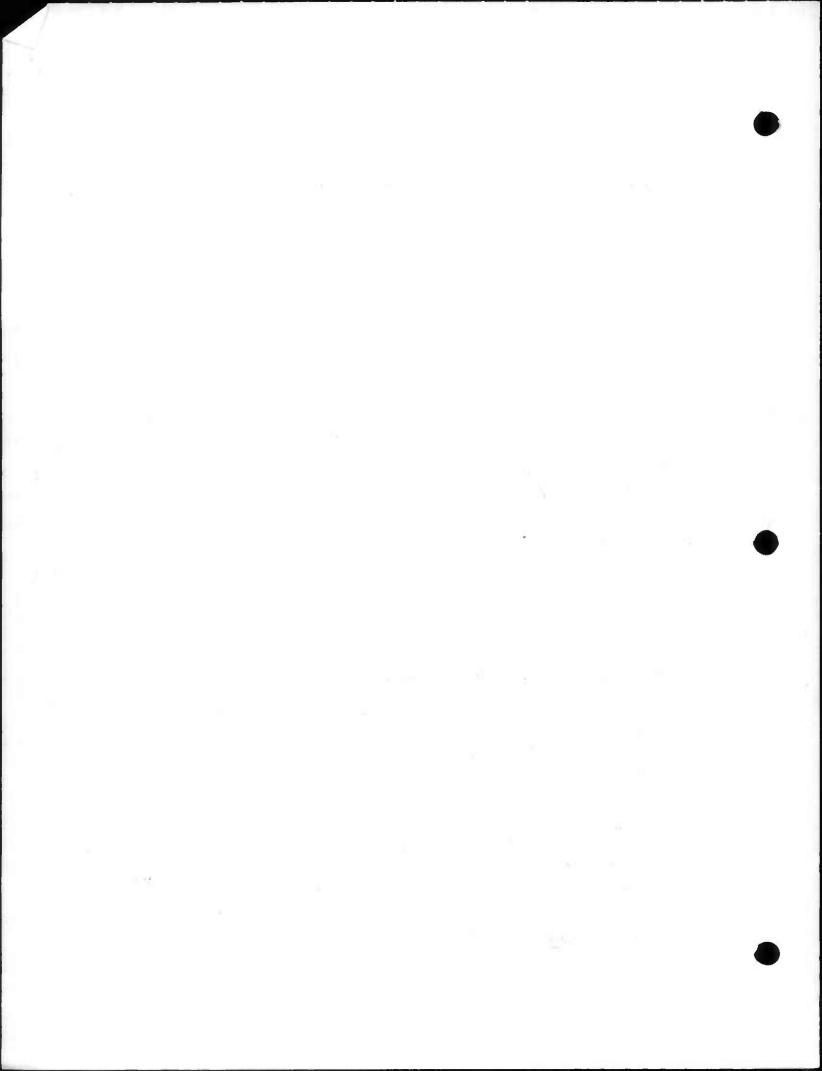
AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flours after death. Page 6 may be retained by the hospital or attending physician. AL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	i item 26 is marked, of item 25 shows any injury, of other usumanc event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHY THE FUNERAL DIRECTOR: After this flied within 72 hours after death with	MPUNIANI: II NEM 26 IS MARKE

											(95	15912
	1 - FOR REGISTRAR	STATE OF N	IARYLAND C	DEPAR	TMEN	T OF H	IEALTH DEAT	AND I	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)				_				MONT	OF DEATH	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	Thom					1261				8	1995	0700 A "
	7.110.000	5. SEX	6. AGE (In yrs. Ia	st birthday) YRS.	IF UNDS	DAYS	IF UNDER	MIN.		OF BIRTH h, Day, Year)		8. BIRTHPI Country)	LACE (State or Foreign
	218-18-2807 Ba. FACILITY NAME (If not institution, give s		70	THS.	01 01					.18,1			ryland_
Œ	Shady Grove A		t Hosp	ital			Vill		ATH			nty of DEA	
DIRECTOR	RESIDENCE OF DECEDENT	a v ch o i b	o nonp	1041	1,	1001	A T T T	-			MO	nego	мету
RE(Manager 1 and Manager					OR LOCAT	TION					1	IOd. INSIDE CITY
		tgomery		Da	mas	cus						1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER	D =1- M		101. ZIP CODE								AT COUNTRY?	
W	25704 Valley										S.A.		
	1 Never Married 2 Married		YES 2	RMED NO	13	If yes, sp	ecify Cuba	n, Mexica	n, Puerto i	17 (Specify Yes Rican, etc.)	or No-	Black,	- American I <i>nd</i> ian, White, etc.
ВҰ	3€XWidowed 4 ☐ Divorced	World				1 TYES	2X NO	Specify	/:			Specify:	Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	18a Di	ECEDENT'S	USUAL	OCCUPATION	ON	_	16b	. KIND OF BU	SINESS/INC		
	Elementary/Secondary (0-12)	College (1-4 or 5 +) ide	live kind of v	vork done e retired.	during mo	st of workin)g		TT C	0		
MP	5th		IVI	aint	ena	nce	WOI	Ker		U.S.	GOV	ernm	ent
8	17. FATHER'S NAME (First, Middle, Last)									Middle, Maiden	Surname)		
BE	Harry Dorsey 19a. INFORMANT'S NAME (Type/Print)									ewell			
임	Mary V. Dennis		19	2570	4 V	all (nd Number	or Aural A	Ter	oer, City or Tow	n, State, Zip	masc	20872 us, Md.
	20a. METHOD OF DISPOSITION		20b. PLACE						DAT			City or Town	
	Puriel 2 ☐ Cremation 3 ☐ Reme 4 ☐ Donation 🦻 ☐ Other (Specify)	oval from State	cemetery, cre	ematory or of dvi1	her pleca)		7.5	5/1				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1 WOO	avii	22	. NAME AP	ID ADDRES	SS OF FAC	CILITY				y, Md.
11	1 Thut I)	1.111.	/										eralHome
	23. PART I. Enter the diseases, or o	complications the	caused the de	eth. Do n	ot ente	64()	Ri	dge	Roa	ad, Dai	masc	us,	Maryland
	IMMEDIATE CAUSE (Final	List only one cau	se on each line	p.			as or ay.		T WE COLO	nec or respi	ratory an	wat,	Interval Between
		CARTIC	20 IN) T	KT	NA)	145	MID	n wh	L. E			Onset and Death
	resoluting in country	AS TO	OR AS A CONSE	OUENCE OF	7:		110	101	7-6.7	06			O DAT
Z	Sequentially list conditions.	THRO	MBOCY	TO PE	3/11	4							4 DAYS
Ĕ	If any, leading to immediate	DUE TO	OR AS A CONSE	OUENCE OF):								
ERTIFICATION	CAUSE (Disease or Injury	c	OR AS A CONSE	OHENCE OF	D.								
E	that initiated events resulting in death) LAST		on Ao A Congr	OULINCE OF	,.								
S		d											
Ä	PART II. Other algorificant condition	s contributing to	deeth but not	resulting i	n the u	nderlylng	g cause g	liven in I	Part I.	24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS WAILABLE PRIOR TO
MEDICAL	EM III (SEME)	FEIVING	FA	Thuk	E				-	1 [] YES 2	SONO	0	OMPLETION OF CAUSE F DEATH?
	DID TOPACCO LICE CONTE	NINITE TO CAL	105.05.554			=						1	TYES 2 XNO
PHYSICIAN:	DID TOBACCO USE CONTI	KIBUIE IO CA		E OF DEAT			UNC	ERTAIN	1 [
S	EXAMINER?	HOSPITAL:			OTHE	R:							
H	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIME	OF	28c, INJ	e 5 Re	sidenca I		(Specify) CRIBE HOW II	NJURY OCC	CURED	
ВУ Р	1 Natural 5 Pending	(Month, De	y, Year)	INJI	URY M	WO	RK? 'ES 2	NO				-	
ED B	3 Suicide 8 Could not be	28s. PLACE OF	INJURY — At he	me, ferm, a	treet, fac	tory, office			281. LOCA	ATION (Street a	and Number	or Rural Rou	te Number,
ETE	4 Homicide determined	- Sinding,	(City (or Town, State)			
PLL	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledge, de	ath occurre	d at the	time, date	and place,	and dua	to the cau	se(a) and men	iner as state	ed.	
COMPL	one) 2 MEDICAL EXAMINE	R: On the basis of ax	amination and/or	Investigation	n, In my	opinion, d	eath occur	ed at the t	time, data	and place, an	d due to th	e cause(a) a	nd manner as stated.
ш	295. SURBATURE AND STITLE OF CENTIFIES	/					29c. LICE	NSE NUM	BER		29d. DATE	E SIGNED (M	fonth, Day, Year)
0 8	Corty. AU	ough	1 M	10			D 2	654	00		M	A4 8	1995
	38. NAME AND ADDRESS OF PERSON WHI	COMPLETED CALL	F OF DEATH ATE	44 070 77	FR-1-41								

USE OF DEATH (ITEM 27) (Type, Print) mberge 162
32. Receipt Any's Signature
Julia Dauchen Reviels

220

31. DATE FILED (Month, Day, Year)
MAY 1 0 1995



	REGISTRAR		CE	ERTIF	ICATE	OF DEATH		REG. NO			
1	1. DECEDENT'S NAME (First, Middle, Last)				T.			DATE OF DEATH			3. TIME OF DEATH
	THOMAS DEELY	Thomas Mid	chael I	Deelv	. Sr.			May 7	1 Q	95	06:00 A.
- 1	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las		IF UNDER 1 Y	EAR IF UNDER 24 HR	$\overline{}$	DATE OF BIRTH	17		IPLACE (State or Foreign
	094-14-2804	1 📉 M 2 🗆 F	73	YRS.	-	AYS HOURS MIN	. (Month, Day, Year)	921	Countr	York
	Se. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TO	OWN OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
DIRECTOR	St. Agnes Hospita	1				Baltimore				Non	e
<u> </u>	10e. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OR	LOCATION					10d. INSIDE CITY
5		Baltimore				Catonsvil	le				LIMITS? 1 YES 2 NO
LONEHAL	100. STREET AND NUMBER 719 Maiden Choice	Lane. HR	235			10f. ZIP CODE 21228					tates
É	11. MARITAL STATUS	12. WAS DECEDENT E		MED	1 12 1/2	S DECENDENT OF HIS	BANKO O	0101110 1014			- American Indian,
2 1	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 V	YES 2 NO OR DATES	10	If ye	es, specify Cuben, Max YES 2 [X NO Sp	xican, Pu		or No-	Black Speci	t, White, atc.
	15. DECEOENT'S EDU	1951-197		CEDENT'S	USUAL OCCU	IPATION		16b, KIND OF BU	SINESS/IN	DUSTRY	White
COMPLEIED	(Specify only highest grade Elementary/Secondary (0-12)		(G	Do NOT us	work done duri	ng most of working		United			
	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Na	aval	Offic	er		Nava			-
5	17. FATHER'S NAME (First, Middle, Last)		210				NAME /	First, Middle, Maiden			
	William Dee	·1v						Relihan	Gurname)		
	19a. INFORMANT'S NAME (Type/Print)	-1	101	b. MAII INC	ADDRESS /S	treet and Number or Ru			on Cont. W	n Codes	21228
2	Felice R. Deely					Choice La				,	
	20a. METHOD OF DISPOSITION										
	1X Buriel 2 Cremetion 3 Ram 4 Donation 5 Other (Specify)	oval from Stata	cemetery, cre Arlir	matory or o	ther plece) Natio	May 16 1 onal Ceme	995 tery	Arl:	ingto	on, V	irginia
į	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NA	ME AND ADDRESS OF	FACILIT	Robert	A. I	umph	rey Funera
	Allia 4.00 (9)	Kaulla	MC	00348	Home	e/Bethesd	a-Ch	nevy Cha	se,]	inc.,	7557
\dashv	23. PART i. Enter the diseases, or o	complete tions that or				consin Av					
	shock, or haert failure.	List only one ceuse	on each lina		iot enter th	e mode or dying, a	PUCH MM	cardiac or reap	iretory ar	reat,	Approximate interval Between
ł	IMMEDIATE CAUSE (Final disease or condition										Onset and Dear
	resulting in deeth)	a. PULMONAR	Y EDEM			ECTASIS					2 Days
. 1	_	·			•	RCINOMA,	raai	r kidnev			2 Months
CENTIFICATION	Sequentially list conditions, if any, leading to immediate		AS A CONSEC			KOINOIM,	DET.	KIDNEI			2 MOILIIS
3	cause. Enter UNDERLYING CAUSE (Disease or injury	c									
	that initisted events	OUE TO (OR	AS A CONSEC	DUENCE O	F):						
	resulting in deeth) LAST	d									
	DADT II Other significant condition	o a posidir visio e do de		141							
	PART II. Other significent condition	s contributing to de	eth but not r	esulting	In the unde	riying cause givan	In Part	i. 24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDING: AVAILABLE PRIOR TO
								1 VES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
								A			X YES 2 NO
	DID TOBACCO USE (CONTRIBUTE 1	O CAUS	SE OF	DEATH	YES N	10 [₹			
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				28. PLACE OF DEATH	(Check o	nly one)			
	1 TYES 2 XNO	1 X Inpatient 2 EF	NOutpatient 3	□ DOA	OTHER:	Home 5 🗆 Realden	ce 6 🗆	Other (Specify)			
	27. MANNER OF DEATH	28s. DATE OF INJ (Month, Day,		28b. TIM	E OF 28	c. INJURY AT WORK?	28d	. DESCRIBE HOW	NJURY OC	CURED	
1	1 XNatural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			YES 2 NO					
	3 Suicide 6 Could not be	28a. PLACE OF IN building, etc.	IJURY — At ho	me, farm,	etreat, factory	offica	281.	LOCATION (Street		r or Rural R	loute Number,
8	4 Homicide determined		(dpoony)					City or Town, State;			
	290. CERTIFIER 1 XCERTIFYING PHYSI	CIAN: To the best of my	knowledge de	ath occur	ed at the time	data and place, and	due to th	a causa(a) and ma		da d	
	(Check only one) 2 MEOICAL EXAMINE										and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	-01									
4	I ellean	- O Fred	len !	9m	D	29c. LICENSE					(Month, Day, Year)
2	20 NAME AND ADDRESS OF BERGES				-	טע	4964	+	I	ay 8	, 1995
	30. NAME AND ADDRESS OF PERSON WH										
	Dr. William J.	Hicken St.	Agnes	Hos	pital	900 Cato	n Av	venue Ba	ltimo	ore,	MD. 21229
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S		. 0 .00							
- 16	MAY 12 100	Chilles dille	when the	Adalla							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mouls after death. Page 6 may be retained by the hospital or attending physician.

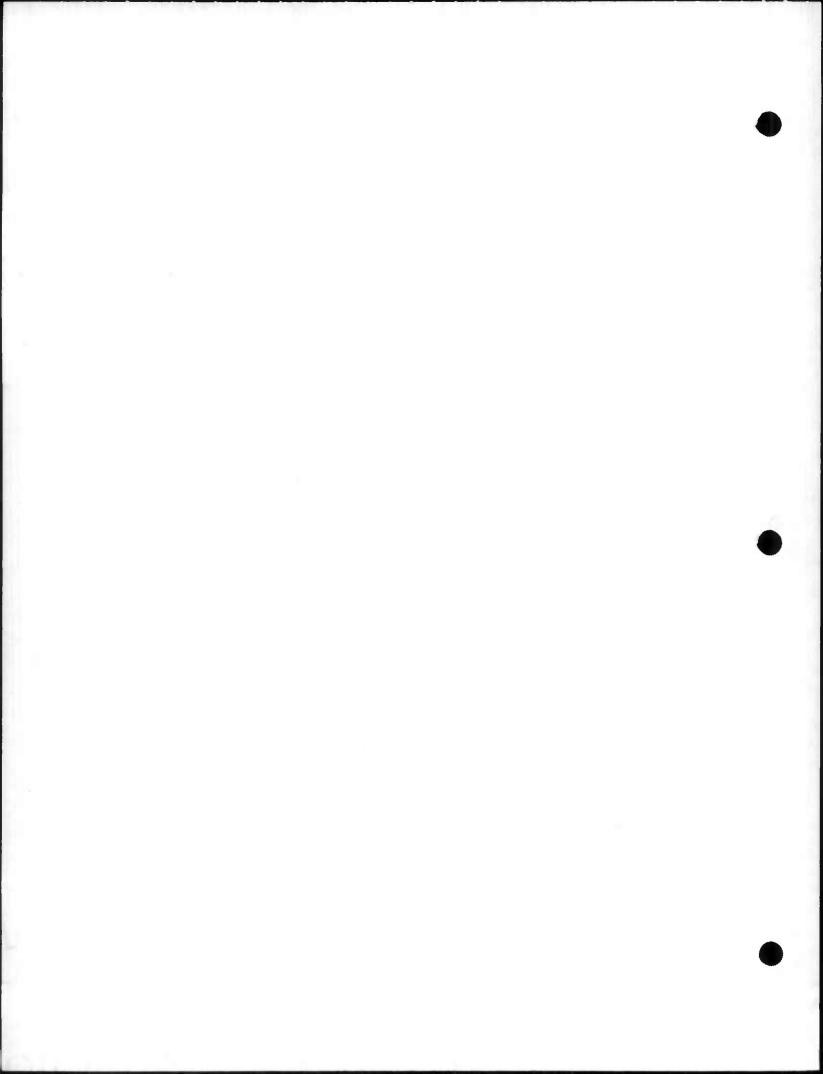
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

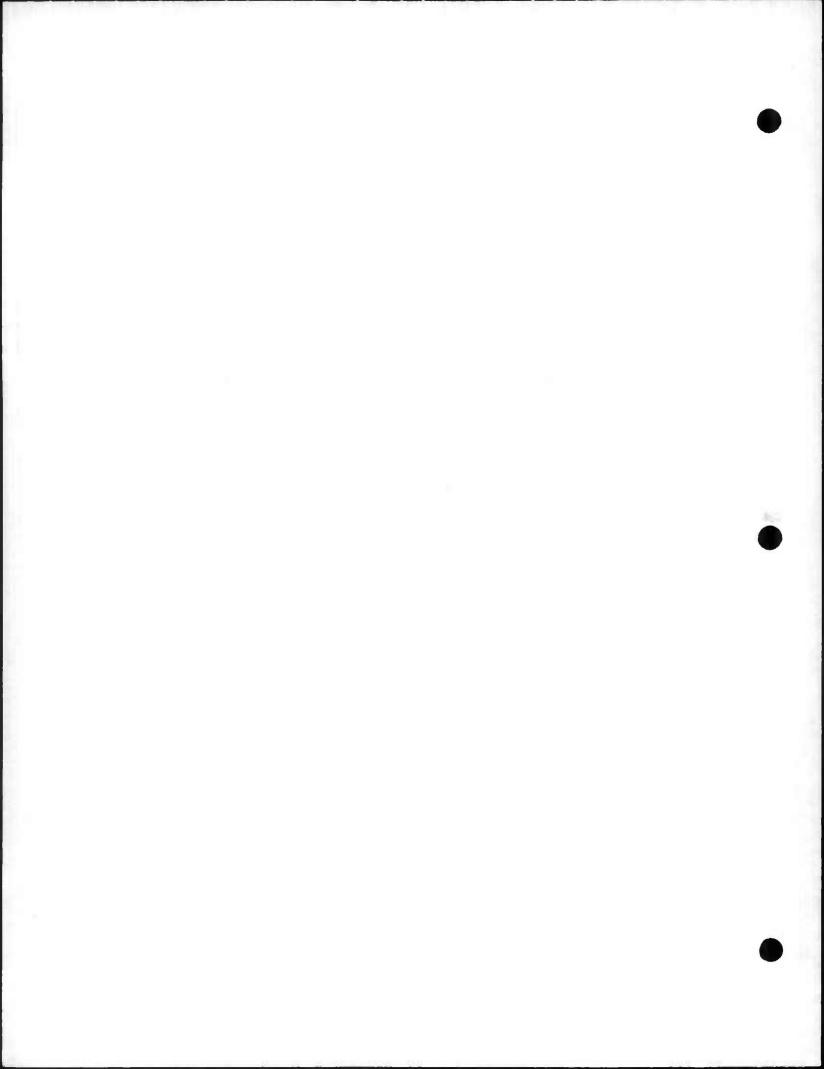
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,	
ATTENDING PHY	ECTOR: After this is after death wit	n 28 is marke	
TO THE HOSPITAL OR	TO THE FUNERAL DIR	IMPORTANT: If iter	

A	1 + 1	# 10	=1.01			M	1	95	5 1	5914
111	mended #7 1 - STATE REGISTRAR	STATE OF MARYI	LAND / DEPAI CERTIF	RTMENT OF	HEALTH AN	D MENT	AL HYGIEN	n e	ry (ounty
	1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH DOU	IGHERTY				MON			YEAR 3	. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEA		Ma v	7 19	95	6. BIRTHPL Country)	12:15 P. M ACE (State or Foreign
	575-34-8349 1 9a. FACILITY NAME (If not institution, give street	t and number)	YRS.		N OR LOCATION OF	Judi	12,	1916	New NTY OF DEA	York
TOR	Collington Life Ca				llville	PUCAIN	13		orge's	
DIRECTOR	Maryland Prince	George's		itchell						Dd. INSIDE CITY LIMITS? YES 2 X NO
FUNERAL	10450 Lottsford Roa	ad, #1202			20721				ted St	tates
E E	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER I FORCES? 1 \times YES IF YES, GIVE WAR OR D 1942 - 1	2 NO	13. WAS E	SPANIC ORIG exican, Puerto secily:	IN? (Specify Yea Rican, atc.)	or No-	14. RACE — Black, v Specify: Whit	American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPI work done during se retired.)	TION most of working	16	56. KIND OF BUS		DUSTRY	A
MP.	17. FATHER'S NAME (First, Middle, Last)	3	Nurse		1.0.000000000		Public		1th	
BE CO	Herman Eggiman				Emil:	ie Yu				
2	Burtis M. Daugherty	yd (husband			ord Road					le, MD 20721
	20e. METHOD OF DISPOSITION t Burlal 2 A Cremation 3 Remova 4 Donation 6 Other (Specify)	I from State cer	p. PLACE AND DATE gretery, cremetory or o nesapeak	of disposition	(Name of a tory	5-			lle, l	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	L. Ras	2	Rapp	Funera Gist Ave	1 Serv	vices, Silver	P.A.	ina l	MD 20910
	23. PART I. Enter the diseasea, or com- ahock, or heert failure. List IMMEDIATE CAUSE (Final disease or condition reculting in death)	Cardi	out line.	many	an	est		ratory arr	reat,	Approximate interval Between Onset and Death
CEMINIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated eventa resulting in death) LAST	DISSA DUE TO (OR AS) A the	A CONSEQUENCE O	of the	- Aon	ta				50kgp pnsc
PHISICIAN: MEDICAL C	PART II. Other algorificent conditions of	on				in Part I.	24s. WAS AN . PERFOR	MEO7	CC DF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION DF CAUSE DEATH? YES 2 NO
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL	UTE TO CAUSE C	26. PLACE OF DEA			AIN 🔯				
101	1 YES 2 XNO 1	OSPITAL:	petient 3 DOA	OTHER: 4 Nursing H	ome 5 🗆 Rasiden	cs 6 🗆 Oth	er (Specify)			
	27. MANNER OF DEATN 1 X Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	26b. TIM	URY	NJURY AT WORK? YES 2 NO	26d. DE	SCRIBE NOW IN	JURY OCC	CURED	
IED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spec	f — At home, term, :			28t. LO	CATION (Street a y or Town, State)	nd Number	or Rural Rout	e Number,
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYINO PNYSICIAL ON MEDICAL EXAMINER: C	N: To the best of my know								id menner as stated.
0 00 0	296. SIGNATURE AND TITLE OF CERTIFIER Start Tules 1	0			29c. LICENSE I		,	29d. DATE		onth, Day, Year)
-	Stephany Trifoglio	, M.D. 750	00 Greenw		rt Drive	, Gree	enbelt,	-		
	31. DATE FILED (Month, Day, Year) MAY 0.9 1995	32. REGISTRAR'S SIGN	iature Randall							



BALTIMORE, MARY	
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1	1. DECEDENT'S NAME (First, Middle, Last))	VEITH	FICATE OF	DEATH	REG. NO		3. TIME OF DEATH
		Jose	Domin	guez		монтн в Мау	1 1995	8:50 A
	4. SOCIAL SECURITY NUMBER N/A	1 💢 M 2 🗆 F	GE (In yrs. lest birthday YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 1, 199	Coun	HPLACE (State or Foreign try) Tyland
Œ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF D		9c. COUNTY OF	
CTO	Holy Cross Hospi			Si	lver Spr	ing	Montg	gomery
DIRECTOR	Maryland 10b. count	w Montgomery		ilver Sp				10d, INSIDE CITY LIMITS? 1 YES 2 X NO
MAL	100. STREET AND NUMBER				f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	8108 Tahona Driv				2090		USA	
В	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 NO	If yes, s		NIC ORIGIN? (Specify Verin, Puerto Rican, atc.) y: E1 Salavad	Spec	E — American Indian, ok, White, atc. White
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	(Give kind o	S USUAL OCCUPATE	ON ost of working	16b. KIND OF BU	SINESS/INDUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	itte. Do NOT	,		N/A		
NO.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)	
BE	Jose N. Domingue:	Z			Mar			
2	Jose N. Domingue	Z				Route Number, City or Tow Ver Spring		901
	20a, METHOD OF DISPOSITION 1 Burlat 2 A Cremation 3 Read	nort from State	20b. PLACE AND DAT	E OF DISPOSITION (N			CATION — City or To	
	4 Donation 5 Other (Specify)	M	emetery, crematory or [etropoli	tan Crema	tory 5	/4/95 Alex	andria,	Virginia
	· Mark	. //ille		500 U	nviersity	lins Funer Blvd. W.	Sil.Spr.	Inc. MD 20901
	23. PART I. Enter the diseases, or ahock, or heert fellure. IMMEDIATE CAUSE (Finsi disease or condition resulting in desth)	Liet only one cause or s. Carca to T DUE TO (OR A	each line.		Failu	h as cerdiac or resp	iratory arrest,	Approximate Interval Between Onset and Deat
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST	b. Extrev DUE TO (OR A: C. Respi	S A CONSEQUENCE	nmat	write	ency	-	
7	PART ii. Other significant condition	ns contributing to desti	but not resulting	In the underlyin	g ceuse given in	Part I. 24s. WAS AN	MATTO	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
2						1 YES 2	NO	COMPLETION OF CAUSE OF DEATH?
			OF DEATH A		LINICERTAL			1 YES 2 NO
I: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH 1	ES I NO A	I CHALLER LAID			
2	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ATH (Check only one)				
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF DE	ATH (Check only one) OTHER: 4 □ Nursing Hor	ne 5 🗆 Realdence	6 Other (Specify)		
BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturel 5 Pending Investigation	HOSPITAL: 1/2 Inpetiant 2 = ER/O 26a. DATE OF INJUR (Month, Day, Year	26. PLACE OF DE ulpatient 3 DOA Y 28b. Ti	ATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN. IJURY M 1	ne 5 Residence JURY AT DRK? YES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW I		Pour Marke
ED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Neturel 5 Pending	HOSPITAL: 1/2 Inpetiant 2 = ER/O 26a. DATE OF INJUR (Month, Day, Year	26. PLACE OF DE urlpatient 3 □ DOA TY 28b. Ti iii	ATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN. IJURY M 1	ne 5 Residence JURY AT DRK? YES 2 NO	6 Other (Specify)		Route Number,
ETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER Check only	HOSPITAL: 1 Inperiant 2 = ER/O 28a. DATE OF INJUR (Month, Day, Yea.) 28a. PLACE OF INJUR	28. PLACE OF DE utpatient 3 □ DOA y) 28b. Ti	ATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN. IJURY M 1 , streat, factory, office	IURY AT PER 2 NO	6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street is City or Town, State) to the cause(a) and man	and Number or Rural o	
BE COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 Pending Investigation 2 Accident 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND FITLE OF CERTIFIE	HOSPITAL: 1 Inpetiant 2 = ER/O 28a. DATE OF INJUR (Month, Day, Yea) 28a. PLACE OF INJUR building, etc. (S SICIAN: To the best of my kn ER: On the basis of axamins	28. PLACE OF DE uripatient 3 □ DOA TO 197 □ 28b. Till 197 □ At home, farm pecify) owledge, death occurtion and/or investigated to 10 and 10 an	ATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN. IJURY M 1 , streat, factory, office	IURY AT PER 2 NO	6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(a) and mar time, data and place, an	and Number or Rural o	a) and manner as stated.
E COMPLETED BY PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Impatiant 2 = ER/O 28a. DATE OF INJUR (Month, Day, Yea. 28a. PLACE OF INJUR building, etc. (S SICIAN: To the beat of my kn ER: On the basis of axamins	28. PLACE OF DE unpatient 3 □ DOA TO 19 □	ATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN. IJURY M 1 , streat, factory, office	ne 5 Residence JURY AT PRK? YES 2 NO is a and place, and due death occured at the	6 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(a) and mar time, data and place, an	and Number or Rural nner as stated, id due to the cause(i	a) and manner as stated.



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		is and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
	an.	ransit
BALTIMORE, MARYLAND 21215-0020	executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	burial-t
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp
SALIMONE, MANIEME	Company of the Compan

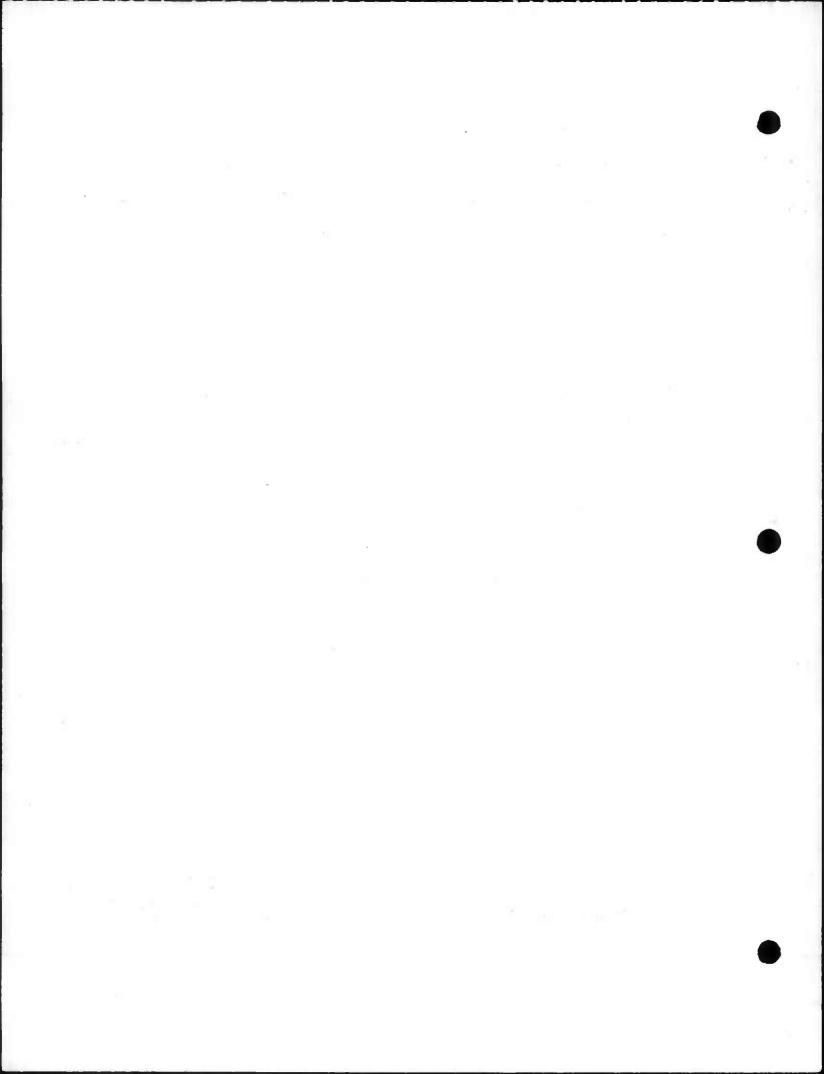
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

1. DECEDENT S NAME (First, Middle, Last)

1. DECEDENT CAPTANIO DECARD OF DEATH MONTH DAY OF TANIO DECARD OF DEATH MONTH DAY OF TANIO DECARD OF DEATH MONTH DAY OF TANIO DECARD OF TANIO DE

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR												3. TIME OF OEATH			
			EPH GAETA	ANO DI	CARLO						MAY 8	6:45 A M			
	4. SOCIAL SECURITY NUMBER	3	5. SEX	6. AGE (In yrs	s, last birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE	OF BIRTH		BIRTHPLACE (State or Foreign Country)		
	137-03-6923 9e. FACILITY NAME (If not instit	tution olim et	1 M 2 D F	81	YRS.	1.55				June	28, 1			Italy	
OB	NATIONAL RESIDENCE OF DECE			CENT	ER	96. CITY		HESD		EATH			ONTG	OMERY	
ם		DENT 0b. COUNTY				V TOURI C									
DIRECTOR	Maryland		gomery		10c. CITY, TOWN OR LOCATION Kensington								10d. INSIDE CITY LIMITS? 1 YES 2X NO		
- 1	10e. STREET AND NUMBER				10f. ZIP CODE							HAT COUNTRY?			
FUNERAL	5109 Fla	anders	Avenue		20895							States			
2	11. MARITAL STATUS 1 Never Married 2 Married	arried	12. WAS DECEDEN FORCES? 1								N? (Specify Yes Rican, atc.)	— American Indian,			
BY	3 Widowed 4 Divorce	F-10-11	IF YES, GIVE W	AR OR DATES	WW II	: '	1 TYES	2 X NO	Specif	y:			Speci	White	
	15. DECED (Specify only h	ENT'S EOUC	ATION completed)	18a	. DECEDENT'S (Give kind of	work done o	CCUPATH during mo	ON ost of worki	ing	16	. KIND OF BU	SINESS/INC	USTRY		
PLET	(Speciny only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)														
COMPL	17. FATHER'S NAME (First, Midd	fle, Last)	31		Admiin.	ISTI	itor		HER'S NA		County Middle Meiden		ernme	ent	
BEC	17. FATHER'S NAME (First, Middle, Last) Ulderico DiCarlo Not Available														
0	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 0 3												30341		
	Joseph G. Dicarlo 1843 West Nancy Creek Drive, Atlanta, Georg														
	20b. METHOD OF DISPOSITION 1														
	EL SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY														
	M00846 Robert A. Pumphrey Funeral Home/Bet Chevy Chase, Inc., 7557 Wisconsin A Bethesda, Maryland 20814-3501												Bethesda- n Avenue		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate interval Between														
	IMMEDIATE CAUSE (Final disease or condition			4 500,400,00										Onset and Death	
1	resulting in death)				ARTER		SEAS	E							
2					HEART		IDE								
2	Sequantially list condition if any, laading to immedia	ta			SEQUENCE O		JILL								
2	CAUSE (Disease or Injury		DUE TO	OR AS A COA	SEQUENCE O	FI.									
CERTIFICATION	that initiated events resulting in death) LAST		332,10	(011 NO 11 001	OLGOLIIOL O	, ,.									
	PART II. Other eignificant	conditions	contributing to	death but n	ot resulting	in the un	derlyin	n causa	given in	Part I	24a. WAS AN	AUTOBEV	245	WERE AUTOPSY FINDINGS	
DICAL								, 00000	giveir iii		PERFOR	MED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
											1 TYPES 2	U NO		OF DEATH?	
z	DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF D	EATH YE	S 🗆 1	NO [UNC	ERTAI	л D					
5	25. WAS CASE REFERRED TO MEXAMINER?	MEDICAL	HOSPITAL:	26. P	LACE OF OEA	OTHER									
2	1 TYES 2 NO		1 Tinpatient 2			4 🗌 Nurs	ling Hom		sidenca		er (Specify)				
BY PHYSICIAN:	1 Natural 5 Per	nding estigation	28a. DATE OF (Month, Di	ily, Year)	28b. TIM	URY M		URY AT PRK? YES 2] NO	28d. DE	SCRIBE HOW I	NJURY OC	CURED		
- 48	3 Suicide 8 Co	uld not be	28a. PLACE O building,	F INJURY — A atc. (Specify)	1 home, farm,	street, facto	ory, offic			281. LOC City	ATION (Street a or Town, State)	and Number	or Rural R	oute Number,	
	an occurren							_							
3 Suicide 8 Could not be detarmined building, stc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.											and menner se stated.				
פני	29b. SIGNATURE AND TITLE OF	F CERTIFIER						29c. LIC	ENSE NUM	ABER		29d. DAT	E SIGNED	(Month, Day, Year)	
2	STRU	logg	· m					MD-	0474	54-L	(PA)	Þ ñ	lay	9,1995	
	J.H. KELLOGG,				(ITEM 27) (Type,	Print)		NA BE	TION	AL N DA M	AVAL M D 2088	EDICA 9-560	AL CI	ENTER	
ľ	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE														
	31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE MAY 11 1995 Julia Dhucker Randell														



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flower after death. Page 6 may be retained by the hospital or attending physician.

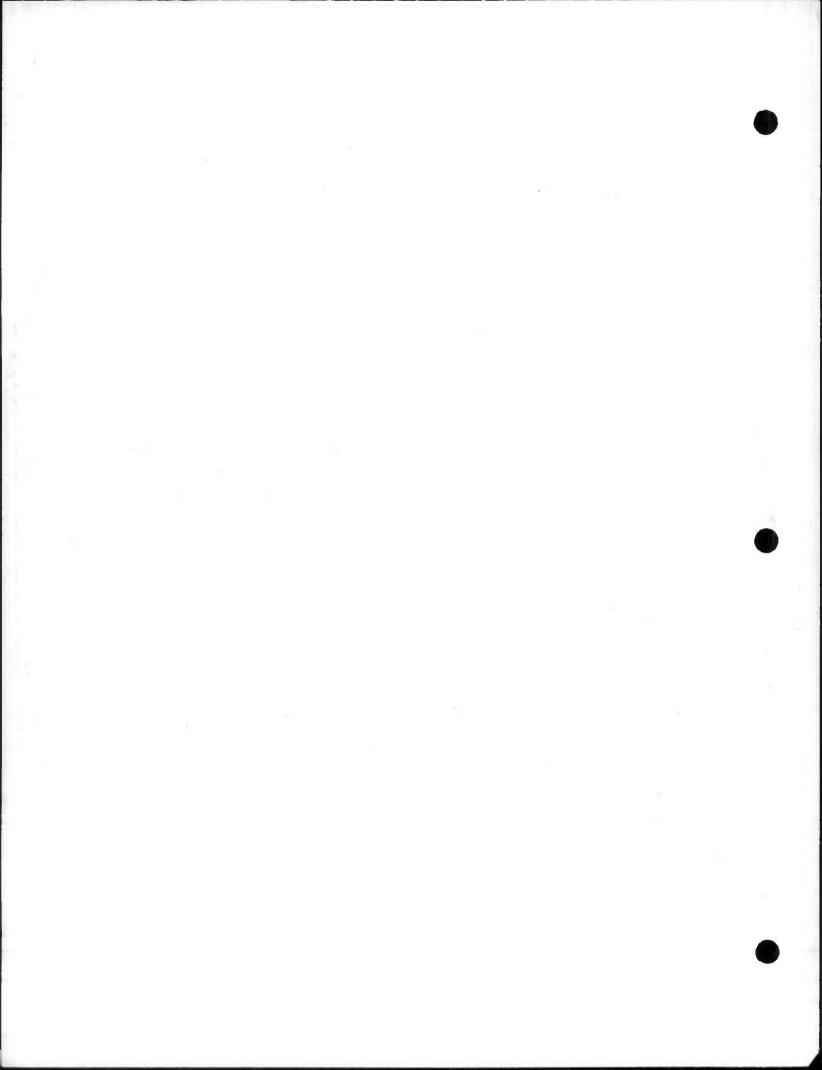
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

1 - FOR STATE REGISTRAR

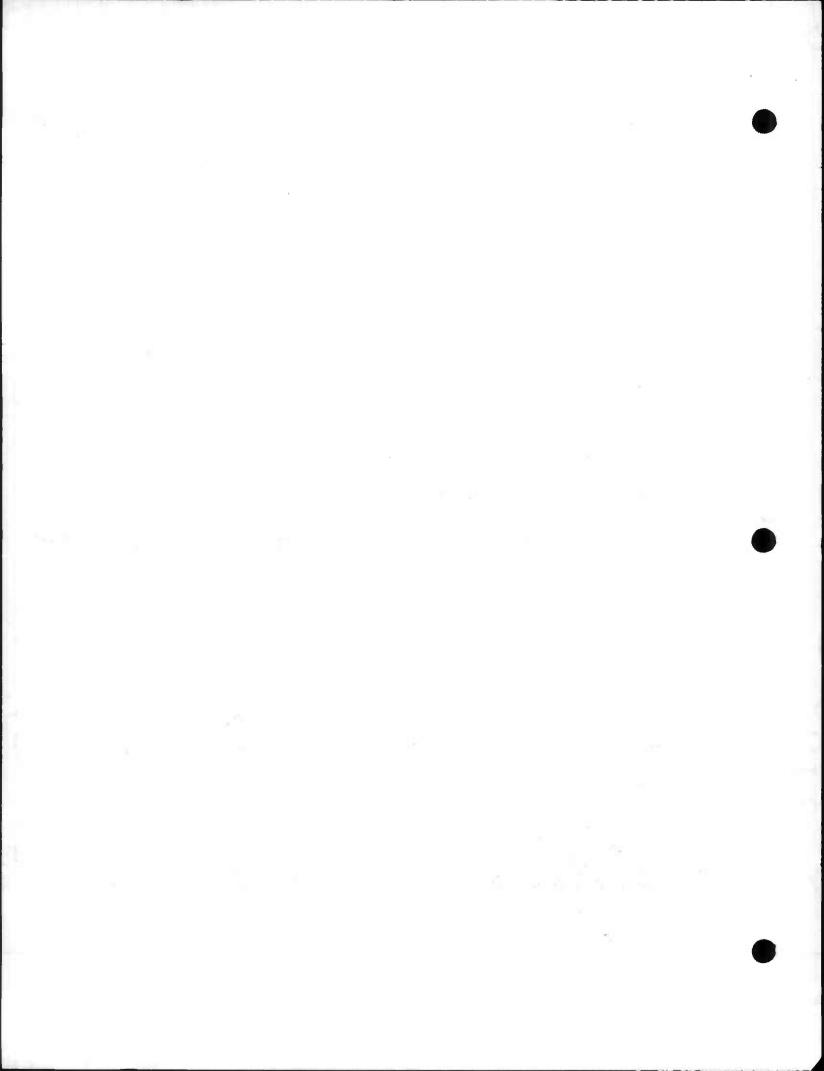
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH												3. TIME OF DEATH				
	Mamie			DeRen	170						H DA	7:10 P M				
	4. SOCIAL SECURITY NUME	ER	5. SEX		rs, lest birthdev)	IF UND	ER 1 YEAR	IF UNDER	24 HRS	May	OF BIRTH	199		PLACE (State or Foreign		
	233-70-3893		1 □ M 2 [X] F	84	YRS.	MONTHS		HOURS	MIN.	(Mont	h, Day, Year)	110	Country	y)		
	9a. FACILITY NAME (If not in		(met and number)	04		9b. CITY, TOWN OR LOCATION OF DE					*			ly		
œ						90. CII				EATH		9c. COU	INTY OF D	EATH		
DIRECTOR	Rockville	Nursi	ng Home	_			Roo	ckvil	le			M	ontgo	omery		
ည္က	10e. STATE	10b. COUNT			10c. CI	ry, town	OR LOCA	ATION						10d, INSIDE CITY		
腊	Maryland	ľ	Montgomer	-V			Roc	kvill	ما					LIMITS?		
	10e. STREET AND NUMBER			101. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?							
BY FUNERAL	4 Grovepoin	t Cour	ct	20854						United States						
<u> </u>	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S	S. ARMED						17 (Specify Ven			- American Indian,		
	1 Never Married 2		FORCES? 1		MNO						Rican, atc.)	0, 140—	Black	, White, etc.		
	3 💢 Widowed 4 🗌 Divo	rced	,	THE STATE OF THE S	•		1 🗆 12	3 2 X NO	Specify	y.			Specif	White		
	15. DEC	EDENT'S EDU	CATION	16	a. DECEDENT'S	USUAL	OCCUPAT	ION	N 16b. KIND OF BUSINESS/III							
	Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done ise retired.	e during m .)	ost of workir	ng							
릴	_		4		Te	Teacher					Publ	lic S	choo	1		
COMPLETED	17. FATHER'S NAME (First, M.	iddle, Last)			18. MOTHER				HER'S NA	ME (First, I	Middle, Malden S	Surname)				
BE (James	Vincer	nt Pinto						Rose	e Dig	jesu					
2	19a. INFORMANT'S NAME (7	/pe/Print)			19b. MAILING	ADDRES	SS (Street	and Number	or Rural F	Poute Numi	ber, City or Town	, State, Zij	p Code)	11		
ř	Emil V. DeR						20854									
	20a, METHOD OF DISPOSITI	ame of	1005	DAT	E 20c. LOC	CATION -	City or To	wn, Stata								
18 Burlei 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) Sunset Memorial Park S.C.												Charleston, W. Virginia				
													umph	rey Funeral		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphre Home/Rockville, Inc., 300 W. Montg Rockville, Maryland 20850-2805												tgomery Ave			
	23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,															
1	IMMEDIATE CAUSE (FIN		LIST ONLY ONE CAL	ise on each	lins.									Interval Between Onset and Death		
	disease or condition resulting in death)	→	Leuk	emia										Years		
	an essening		DUE TO	(OR AS A CO	NSEQUENCE O	r):										
Z	Sequentially list conditi		Pneu	monia										Weeks		
	If any, leading to immed	liete	DUE TO	(OR AS A CO	NSEQUENCE O	F):										
2	cause. Enter UNDERLYi CAUSE (Disease or Inju		D													
CERTIFICATION	that initiated events resulting in death) LAS		DUE TO	(OR AS A CO	NSEQUENCE O	F):										
			d													
	PART II. Other significa	nt condition	s contributing to	death but r	not resulting	in the u	nde riyin	ig cause g	iven in	Part I.	24a. WAS AN /	WTOPSY	24b.	WERE AUTOPSY FINDINGS		
EDICAL											PERFORI			AMAILABLE PRIOR TO COMPLETION OF CAUSE		
										_	1 TYES 2	Хио		DF DEATH?		
Σ	DID TOBACCO U	SE CONTI	PIRLITE TO CA	LISE OF I	DEATH VI	EC []	NO F	T HNC	ERTAIN				- 1	1 TYES 2 NO		
4	25. WAS CASE REFERRED TO				PLACE OF DEA				LIVIAII	<u> </u>		_				
PHYSICIAN	EXAMINER?	120000	HOSPITAL:	FR/Outpetler	nt 3 🗆 DOA	OTHE	R:	ne 5 🗆 Re	ald-sa-	4 D 000						
	27. MANNER OF DEATH		28s. DATE OF	INJURY	28b. TIN	E OF	28c. IN.	JURY AT	siderice		CRIBE HOW IN	JURY OC	CURED			
6		Pending nvestigation	(Month, D	ay, Year)	in.	JURY M		YES 2	NO							
- 1	a D sut-te-	Could not be	28e. PLACE O	F INJURY - A	At home, farm,	street, fac	ctory, offic	:a		281. LOC	ATION (Street ar	nd Number	or Rural R	oute Number,		
MPLEIED		ietermined	bullaing,	atc. (Specify)						City	or Town, State)					
ا ۲	29a. CERTIFIER 1 K CERTI	IFYING PHYSI	CIAN: To the best of	my knowledge	a deeth conum	ad at the	alma alab	and store	and due	a. ab	diament et	a love				
į														and menner as stated.		
3							opinion, (and place, and					
R I	29b. SIGNATURE AND TITLE	OF CERTIFIER	1 11.1	11.	o as	7			NSE NUM			29d. DAT	E SIGNED	(Month, Day, Year)		
2 ∦	30. NAME AND ADDRESS OF	DEDOOM INT	VVVV	your	1	7			1978	35			5/1	14>		
							-							/		
	Frauke West	pnal,	M.D., 80	y Veii	rs Mill	L Roa	ad,	Rockv	ille	, Ma	ryland	20	851			
	31. DATE FILED (Month Ony.	2 1991	Julia d	MULLEN	Rowlall											
[- 1000			- an ordered											



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

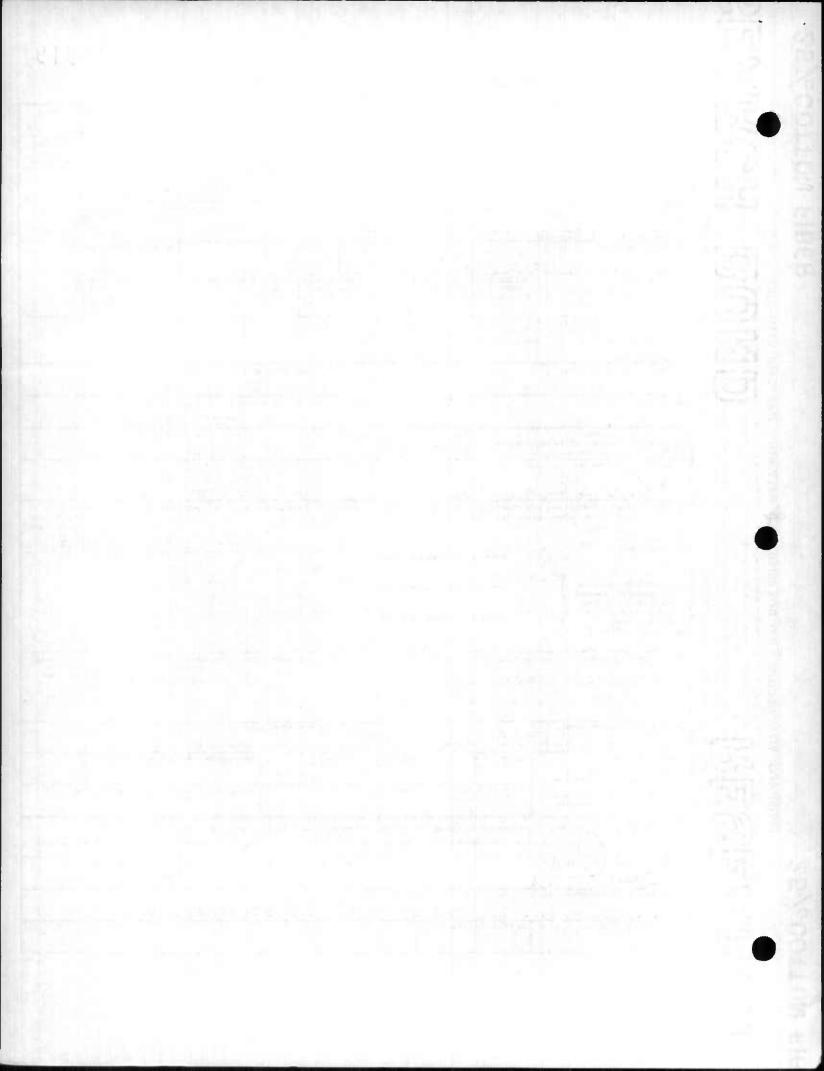
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR												3. TIME OF DEATH	
	Frances	Cather	ine Deich	ıman						May 11,	995	YEAR	12:00 M
	4. SOCIAL SECURITY N		5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER	DAYS	IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
	488-09-017		1 M 2 X F	87	YRS.	MONTHS	UATS	HOURS	Mire.	ept 5, 190	07		ssouri
000	9a. FACILITY NAME (# n		street and number)			-		R LOCATI		EATH		NTY OF D	
P	500 Main					New	Wir	ndsor			Car	roll	
DIRECTOR	10a. STATE	10b. COUNT	гу		10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY
1 2	Pennsylvan:	ia D	auphin		Har	risb	urg				LIMITS?		
¥	100. STREET AND NUME						101	. ZIP COD	E		10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	3217 Twin	n Ave					_ 1	7109)		U.	S.A.	
5	11. MARITAL STATUS	Married	12. WAS OECEDEN FORCES?	T EVER IN U.S. A	RMED NO					IIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	or No—	14. RACI Blac	E — American Indian, k, White, atc.
B≼													
Ē	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)												
길로	12 Cashier Food Service												
OMPLETED	17. FATHER'S NAME (Firs							18. MOT	HER'S NA	ME (First, Middle, Malden	Surname)		
BE at	Louie									t Rhoads			
1	19a. INFORMANT'S NAM									Route Number, City or Town		,	
9	Norma L. M.						_		rris	sburg, Pa.	_		
examiner must be notified at once. TO BE COM	1 Donation 6 Of	ation 3 🗆 Ran	noval from State	20b. PLACE cometery, cr Carro							cation — npste		
Je L	21. SIGNATURE OF FUNI		CENSEE	Carro	11 01			D ADDRE			upate	au,	riu.
mex	V 116	. /	D(7/	7/2/							776		
	II 23. PART I. Enter the	diseases or	complications the	thousand the d	eath Do	not agree				or, Md. 21			1
D D D	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac er respiratory errest, shock, or heart failure. List only one cause on each line.												Interval Between
\$	disease or condition		Athor	050 000	1 :	10	Wi)	Na	Soral	Par Des	ROL	0	Onset and Death
Vent,	resulting in death)		DUE TO	(OR AS A CONSE			ma	200	JCHO!	av			1917
or other traumatic event, the medical			b										'
ry, or other traumatic	Sequantially list con if any, leading to im cause. Enter UNDER	mediate	OUE TO	(OR AS A CONSE	OUENCE O	F):							
취임	CAUSE (Disease or I		c. DUE TO	(OR AS A CONSE	OUENCE O	e.							
E E	reaulting in death) L	AST	200	,									İ
질			0,										
shows any injury, MEDICAL CI	PART II. Other signif	lcant conditio	ns contributing to	daath but not	raaulting	in tha ur	nderlylng	cause (givan in	Part I. 24s. WAS AN PERFOR		24b	. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO
a a										1 YES 2	K) NO		OF DEATH?
M M										-/			1 YE\$ 2 NO
S Z	DID TOBACCO		RIBUTE TO CA	_				UNC	ERTAIN	1 187	1		
PHYSICIAN:	EXAMINER?	D TO MEDICAL	HOSPITAL:		CE OF DEA	OTHER	3:		912050	1/		. 7.	-
H Y	27. MANNER OF DEATH		28a. DATE OF		28b. TIM		28c. INJ		sidence	28d. OESCRIBE HOW II	MULIBY OC	_	65
A P		Pending Investigation	(Month, E	Pay, Year)		JURY M	WO		NO			001120	
s mar	2 Achigent 3 Distance &	Could not be	28a. PLACE C	F INJURY — At he	ome, tarm,	street, tact	ory, office			281. LOCATION (Street a	and Number	or Rural I	Route Number,
1 28	4 - Homicide	determined	ballally,	wtc. (Specify)						City or Town, State)			
IMPORTANT: It item 28 is marked, or item O BE COMPLETED BY PHYSICIA	281. LOCATION (Street and Number or Rural Route Number, City or Youn, State) 282. CEPTIFIER Constraint 1 CEPTIFIER Constraint 2 CEPTIFIER Constraint 3 CEPTIFIER Constraint 4 CEPTIFIER Constraint 5 CEPTIFIER Constraint 5 CEPTIFIER Constraint 6 CEPTIFIER Constraint 6 CEPTIFIER Constraint 7 In the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 286. SIGNATURE AND TITLE OFFICERITIES. 287. LICENSE NUMBER 288. LOCATION (Street and Number or Rural Route Number, City or Youn, State) 288. LICENSE NUMBER 289. DATE SIGNATURE AND TITLE OFFICERITIES.												
Wo												a) and manner as stated.	
E S												(Morep. Clay, West)	
	DOS 205 ► 1/10495 10. MAME AND ADDRESS OF PRISON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										1495		
F	Control of the Contro	^								21155			1
	Dr. Richa	To be seen and the		emorial	Dr.	West	mins	ter,	Md.	21157		1	<i>V</i>
	31. DATE FILEO (Month, Day, 32. REGISTRAR'S SIGNATURE												
	MAY 12 1995 Julia of walson Randall												



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First,	, Middle, Lest)	Maxis	Elizabet	h Do	nalde	100	DEA		MONTH			YEAR	3. TIME OF DEATH
	ŀ	4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs. ia			_	IF UNDER	24 MD0	May	14,	1995		12:58 p
		216 - 58 -	8993	1 M 2 🗓 F	90	YRS.	MONTHS	DAYS	HOURS	MIN.	May	May 17, 1904 N			
9	5	Laurel Regi	ional					rown irel	OR LOCATI	ON OF D	EATH	Prince George			
1	<u>ج</u> [RESIDENCE OF DEC	10b. COUNT	v		10c. CITY, TOWN OR LOCATION									
Olbecator		Maryland		ce George	е	Laurel								10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
140	4	10e. STREET AND NUMBER				10f. ZIP CODE									HAT COUNTRY?
EI INCO		405 Montgor	nery S			20707							USA		
2	2	11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo			NT EVER IN U.S. A: I YES 2 X	RMED NO		If yes, s		ın, Mexica	in, Puerto F	? (Specify Yea lican, atc.)	or No—	Specif	- American Indian, White, etc. White
FTE	3		EDENT'S EDU				S USUAL O		ION ost of worldi		16b.	KIND OF BUS	SINESS/IND	_	
ū	ų l	Elementary/Secondary (0	-	College (1-4 or 5	- 44	. Do NOT	use retired.)	uoring m	OSE OF WORK	79					
once.		Grade 12			Но	usew	ife				Ov	m Hom	е		
once.	3	17. FATHER'S NAME (First, M	liddle, Last)						18. MOT	HER'S NA	AME (First, A	fiddle, Maiden	Sumame)		
% III	u II	Charles Nel		eebe								oeth G			
TO B		19a, INFORMANT'S NAME (7	ype/Print)		19	b. MAILIN	G ADDRES	(Street	and Number	or Rural	Floute Numb	er, City or Town	n, Stete, Zip	Code)	
be no		Jeanne E. N	Voe		4	105 M	iontgo	omer	y ST	reet	, Lau	rel,	Maryl	.and	20707
must		20a. METHOD OF DISPOSITI 1 © Burlal 2 Crematio 4 Donation 5 Other	n 3 🗆 Ram	noval from State	20b. PLACE cemetery, cr TVV I	AND DATE	of disposon other place) Cemet	erv	lame of		5/1	200. LO	cation —		
9		21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEIE	11		22.	NAME A	ND ADDRE		CILITY				
examiner		D 8 1/1.	110	6/	16							Home,			2 20707
	-	23. PART I. Enter the di	seases of	complications the	t caused the d	eath. Do	not enter	the m	ode of dv	Ing suc	ve. I	lac or resul	, Mar	утаг	Approximate
rent, the medical		23. PART I. Enter the diseases of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Sepsis											Onset and De		
atic event,	- 1			DUE TO	(OR AS A CONSE	OUENCE (OF):								
	NO.	Sequentially list conditions, If any, leading to immediate b. Unknown DUE TO (OR AS A CONSEQUENCE OF):													
ry, or other traumatic	3	Cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):													
9 2		resulting in death) LAST													
		PART II. Other significa	int condition	ns contributing to	deeth but not	resulting	In the ur	derlylr	ng cause	given in	Part I. 24s. WAS AN AUTOPSY		AUTOPSY	24b. WERE AUTOPSY FINDING	
MEDICAL CI	٠ ا	Organic B								24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 M NO			24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
DHYSICIAN		25, WAS CASE REFERRED TO	O MEDICAL					20.5	H ACE OF D	EATH M		-1			
item 23 sh	2	EXAMINER?	o mediane	HOSPITAL:	FB/Outpetlant	1 DO4	OTHE	3:			neck only on				
ō Ž		27. MANNER OF DEATH		28a. DATE OF		28b, TII	_		JURY AT	sidence	6 Other	CRIBE HOW II	NJURY OCC	URED	
marked RY P			Pending Investigation	(Month, L	Day, Year)	IN	JURY M	1 🗆	YES 2	NO					
80 L	s		Could not be detarmined	28e. PLACE (building	OF INJURY — At h , etc. (Specify)	oma, farm,	street, fact	ory, offi	ce			ATION (Street a or Town, State)	ind Number	or Rural A	oute Number,
IMPORTANT: If Item 28	CIMPLE			ICIAN: To the best of a											and manner as stated
PORTA PE C	W 296. SCHATURE AND TITLE OF CERTIFIER							n occured at the time, data and place, and due to the cause(s) and manner as stated be. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, War)							
≅ C	2	30. NAME AND ADDRESS OF	F PERSON WA	O COMPLETED CALL	SE OF OFATH (IT	M 27) /%-	e Print)		DZ4	033			Lije	TY TY	1, 1995
		E.S. Macha		I.D. 321	Prince	Geor	rae S	tre	et, L	aure	el, Ma	arylan	d 207	707	
5		31. DATE FILED (MATA) Voy	t°5 199	5 Jahr	AR'S SIGNATURE	ardall									To the
						30.0									



YEAR

9c. COUNTY OF DEATH

ALLEGANY

1995

1913

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

W.VA.

10d. INSIDE CITY

2:30 P.M.

DIVISION OF VITAL RECORDS, P.O. BOX 68760	21215-0020
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physic	oital or attending physic
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	d for use as the burial

should

Pages 1, 2, 3

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DIRECTOR

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Injury, or other traumatic CERTIFICATION

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marked,

this certificate has be with the State Dept. Item 23

FUNERAL I

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I

DIRECTOR: An hours after deal tem 28 is n

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ROBERT BRUCE DuVALL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 214-05-5376 1 2 M 2 🗍 F 82 9e. FACILITY NAME (If not institution, give street and number b. CITY, TOWN OR LOCATION OF DEATH 74 LAVALE BLVD. LAVALE RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION MARYLAND ALLEGANY LAVALE 10e. STREET AND NUMBER 10f. ZIP CODE 74 LAVALE BLVD. 21502 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-1 Never Married 2 Married If yes, specify Cuban, Maxicon, Puerto Rican, etc.)

1 YES 2 NO Specify: 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) SHEET METAL UNION 8

1 TES 2XX NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A.

14. RACE — American Indian, Black, White, afc. WHITE 16b. KIND OF BUSINESS/INDUSTRY

SHEET METAL 18. MOTHER'S NAME (First, Middle, Maiden Surname,

REG. NO

14

2. DATE OF DEATH

7. DATE OF BIRTH

APRIL 17

монтн МАҮ

MARTHA MADDEN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Specify

74 LAVALE BLVD. LAVALE, MARYLAND 20b. PLACE AND DATE OF DISPOSITION (Nama of

22. NAME AND ADDRESS OF FACILITY

20c. LOCATION — City or Town, State DATE SUNSET CEMETERY MAY 17 1995 CUMBERLAND MARYLAND

> MERRITT-ADAMS FUNERAL HOME DECATUR STREET CUMBERLAND MARYLAND 404

23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, ehock, or heart fellurs. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO JOR AS

Approximata Interval Batween Onset and Death

Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted sysnts reaulting in death) LAST

EXAMINER?

Natural 2 Accident

4 Homicide

1 TYES

ZZ. MANNER OF DEATH

Sulcide

17. FATHER'S NAME (First, Middle, Last)

19a, INFORMANT'S NAME (Type/Print)

4 Donation 6 Other (Specify)

JOSEPH DuVALL

DOROTHY P. DuVALL

21. SIGNATURE OF FUNERAL SERVICE LICENSES

METHOD OF DISPOSITION
Burial 2 Cremation 3 Removal from State

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 - YES NO

24b. WERE AUTOPSY FINDINGS COMPLETION OF CAUSE DE DEATH? 1 TYES 2 NO

IGNED

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL

26s. DATE OF INJURY

26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient 2 - ER/Outpatient 3 - DOA

OTHER: ne 5 🗆 Residence 6 Other (Specify)

26b. TIME OF 28c. INJURY AT WORK? 28d. DE\$CRIBE HOW INJURY OCCURED м

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 DESTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end menner as stated.

MEDICAL EXAMINER nvestigation, in my opinion, death occured at the time, date and place, and due to the cause(a) CERTIFIE 29d. DATE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (And artiful)

9

29c_LICENSE NUMBER

100		
RYLAND	21502	

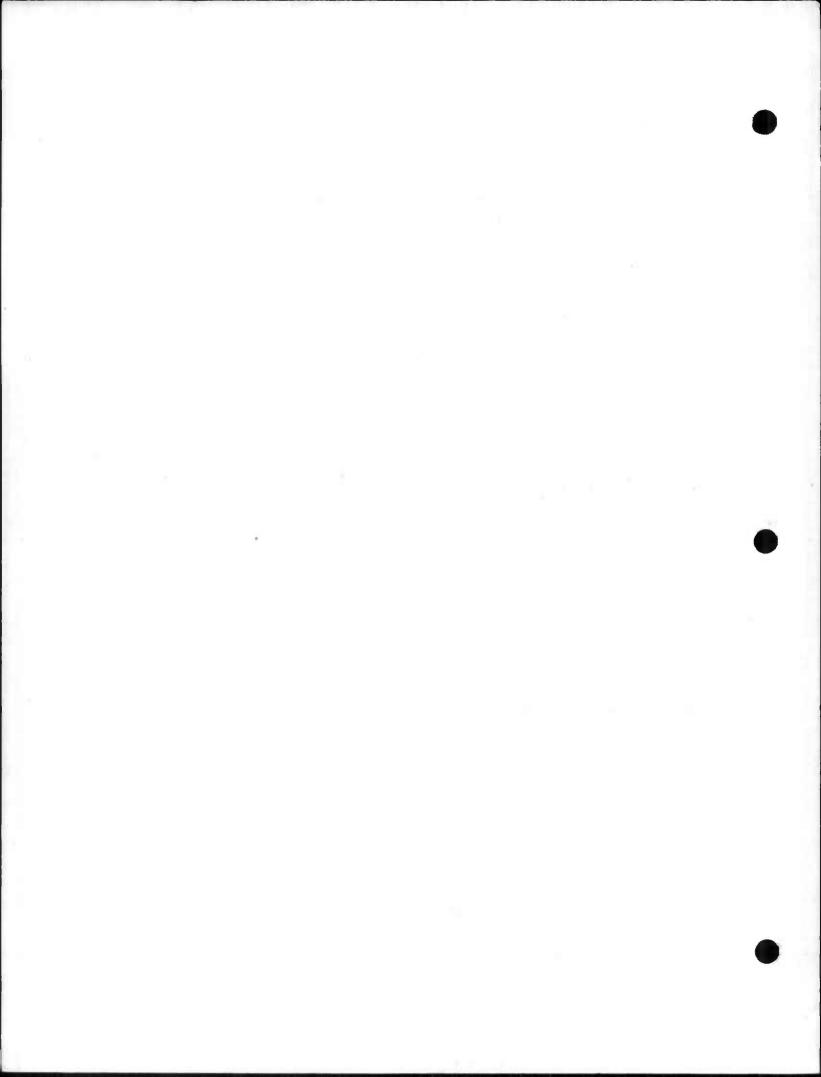
GUY FISCUS 31. DATE FILED (MA

5 Pending

Investigation

8 Could not be determined

500 MEMORIAL AVE CUMBERLAND MA 132. REGISTRAN'S SIGNATURE

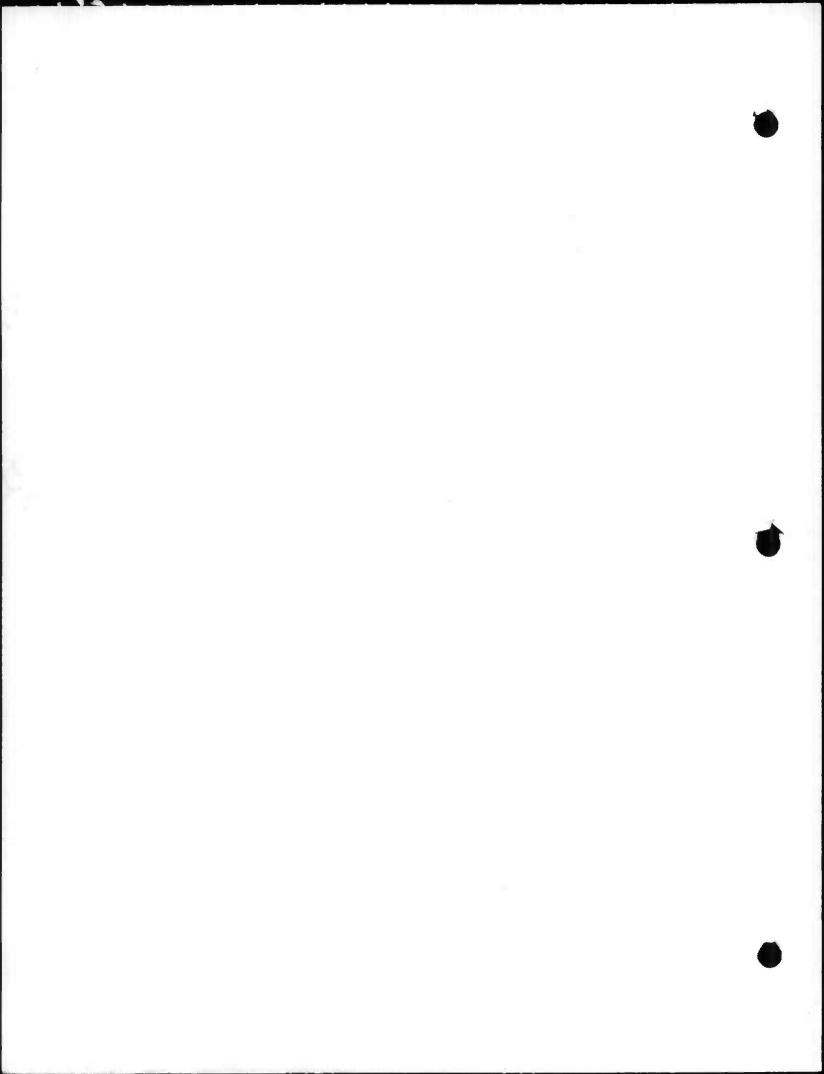


DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within emfours after death. Page 6 may be retained by the hospital or attending physicia	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-ri
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115	ATTE	CTOR
	0R.	DIRE

ling physician. the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with exemplants after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

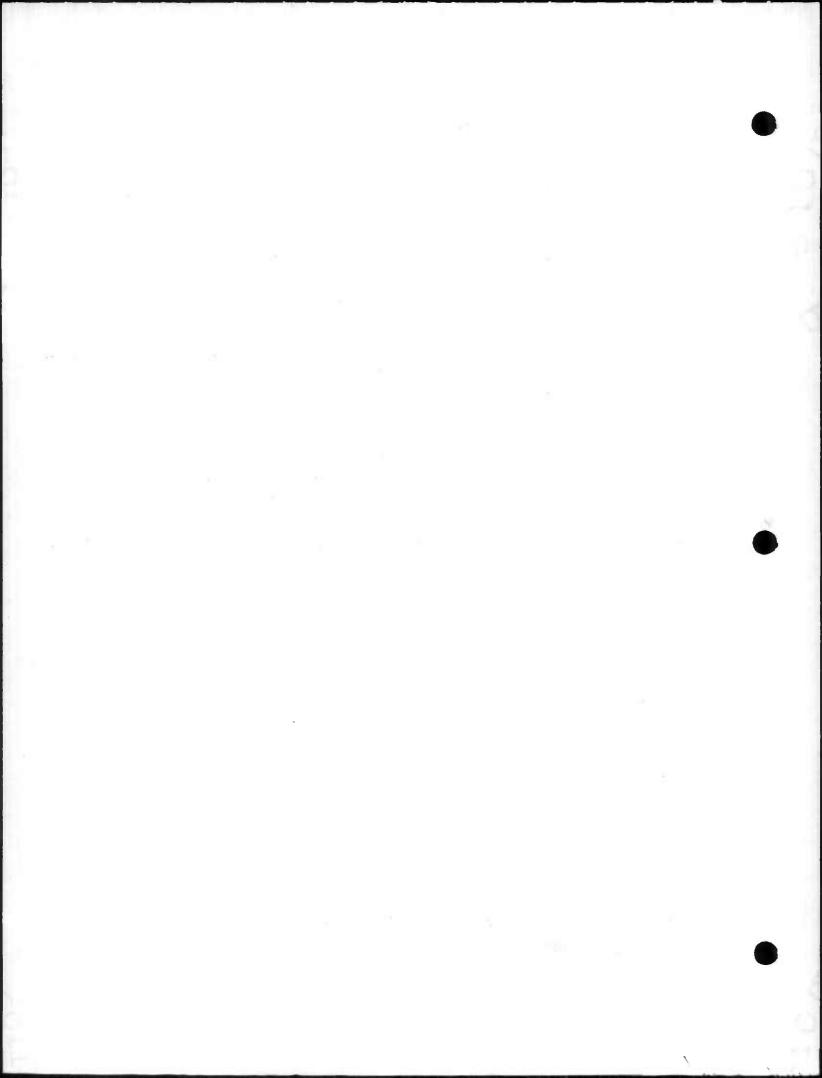
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, L	.ast)				2. DATE OF DEAT	Н		3. TIME OF DEATH
	MARY THE	LMA DA	AVIS			MAY 5,	1995	YEAR	6:00 PM
	4. SOCIAL SECURITY NUMBER		(in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTI	1	8. BIRTH	NPLACE (State or Foreign
	216-66-0615	1 □ M 2 💢 F 4]	YAS.	MONTHS DAYS	HOURS MIN.	1953	Countr	MD	
~	90. FACILITY NAME (If not institution, g				OR LOCATION OF		9c. COU	NTY OF D	DEATN
DIRECTOR	MEMORIAL HOSPI			CUMBER	LAND		AL	LEGA	NY
EC	10e. STATE 10b. CO		10c. CIT	Y, TOWN OR LOC	TION				16d. INSIDE CITY
PHO	MD Al	legany		mberland					LIMITS?
	10e. STREET AND NUMBER		1 00		H. ZIP CODE		10g. CIT	IZEN OF Y	WHAT COUNTRY?
ER	1100 1/2 Virgi	nia Avenue			21502		US	A	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13, WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Specif	y Yes or No-	14. RACI	E — American Indian,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES THO		S 2 X NO Spec	an, Puerto Rican, etc	.)	Speci	k, White, etc.
	15. DECEDENT'S	FRUITE							white
	(Specify only highest g	grade completed)	16a. DECEDENT'S (Give kind of ville. Do NOT us	vork done during n	ION ost of working	16b. KIND OF	BUSINESS/INC	JUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)					TT - /		
COMPLETED	17. FATHER'S NAME (First, Middle, Last,)	Homema	Ker	18. MOTNER'S N	AME (First, Middle, Me	Home		
	Tryin Charle	es Breighner, S	ir			erine (nm	,		
) BE	19e. INFORMANT'S NAME (Type/Print)	DICIGINETY C		ADDRESS (Street		Route Number, City of		Code)	
2	Catherine C. B	reeden	111 Ar	ch Stro	et: Cumb	orland N	D 215	02	
1	20e. METNOD OF DISPOSITION 1 M Burlel 2 Cremation 3 1		PLACE AND DATE	OF DISPOSITION (A			LOCATION -		wn, State
	4 Donation 6 Other (Specify)	R	etery, crematory or or estlawn	Memoria	l Garden	s 05/10	LaVale,	, MD	
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	11.	22. NAME /	ND ADDRESS OF F	ACILITY			
	James	+X)can	ulla.	Scar	pelli fu	neral Hon MD 21502	ne D		
	23. PART V Enter the diseases,	or complications that caused	the death. Do n	ot enter the m	ode of dying, su	ch as cardiac or r	eapiratory arr	reat,	Approximata
	IMMEDIATE CAUSE (Final	ira. Liat only one cause on a	sch line.						Interval Between Onset and Death
	disease or condition resulting in death)	ANOXIC ENCE	PHALOPAT	HY					5 HOURS
		DUE TO (OR AS A	CONSEQUENCE OF	ን:					JIOUKS
S I	Sequentially list conditions,	ASPIRATION							5 HOURS
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		CONSEQUENCE OF	*					
윤	CAUSE (Disease or Injury that Initiated events	C. INTRACTABLE DUE TO (OR AS A	CONSEQUENCE OF						3 MONTHS
E	resulting in death) LAST								
	BAST II Cohor de different e e di								
SAL	PART II. Other significant condi	tions contributing to death be	ut not resulting i	n the underlyin	g ceuse given in	Part I. 24a. WAS	S AN AUTOPSY RFORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						1 X YE	S 2 NO		OF DEATH?
Σ	DID TOP ACCOUNT COL	ALTRIPLITE TO CALLET O							1 - YES 2 NO
AN	DID TOBACCO USE COI		F DEATH YE		UNCERTAI	NKI			
PHYSICIAN: MEDIC	EXAMINER? 1 YES 2 X NO	HOSPITAL:		OTHER:					
Ĭ	27. MANNER OF DEATH	1 Inputlent 2 ER/Output 28a. DATE OF INJURY	28b. TIMI		JURY AT	6 Other (Specify) 28d. DESCRIBE NO	W IN HIRV OC	CHEE	
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY W	YES 2 NO	260. DESCRIBE NO	W INJUNT OCC	OHED	
BY	2 Accident Investigation 3 Suicide 6 Could not	28e. PLACE DF INJURY	— At home, farm, a			261, LOCATION (St	met and Number	or Rural F	Inute Number
日	4 Homicide determined	building, etc. (Speci	ffy)			City or Town, S			oute (Variable),
COMPLET	29a. CERTIFIER 1 CERTIFYING PA	NYSICIAN: To the best of my transle	edge death occurre	d at the time dat	and place and du	to the sever(s) and			
N N		MINER: On the besty of examination							and menner as stated
	29b. SIGNATURE AND TITLE OF CERTI				29c. LICENSE NU				
BE	Miland	1 12			D 36766		▶ M		(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,	Print)	שויים ע		I I	7.1	
	DR. V. POONAI,				MD 215	502			
	31. DATE FILED (Month, Day, har)	REGISTRAR'S SIGNA				- V =			
	MAY 1 0 199	15 Julia Solver	hardall						
		U							DHMH-16 Rev 1/89



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.

			1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH DAY YEAR 3. TIME OF OEATH												3. TIME OF OEATH			
			Ella	ı	S.	Ead	er					May		199		8:30 CM		
		- 1	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (II	n yrs. last birth	"	R I YEAR	IF UNDER	-	7. DATE O	F BIRTH		8, BIRTHI	PLACE (State or Foreign		
10			213-40-832	28	1 🗌 M 2 🔀 F	87	Υ	RS. MONTHS	DAYS	HOURS	MIN.	Nov.	Day, Year)	907	Mar	yland		
phould	- 1		90. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CIT	Y, TOWN	OR LOCATE	ON OF DE	EATH			NTY OF DE			
2,3		CTOR	Frederick	Memor	ial Hos	spita	al	Fi	rede	erick	ς			ede:	rick			
Pages 1,		DIREC	10a. STATE Md.	10b. COUNTY	omery			city, town								10d. INSIDE CITY LIMITS?		
permit.			10e, STREET AND NUMBER						1	of. ZIP CODI	F			I too CIT	ZEN OE W	1 W YES 2 NO		
芸		FUNERAL	20321 Whi	tes F					2083	37			J.S.	Α.				
215-0020 attending physician. Ise as the burial-transit		В	11. MARITAL STATUS 1 Never Married 2 1 3 MW Widowed 4 Dive		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	13.	It yes, s	ECENDENT Copecity Cube	n, Mexica	n, Puerto Ri	(Specify Yes	or No—	14. RACE Black Specif	- American Indian, White, etc.		
1215 r attend use as		ETED		CEDENT'S EDU				NT'S USUAL O			200	16b. I	KIND OF BUS	SINESS/INC	DUSTRY			
21 g or for u			Elementary/Secondary (College (1-4 or 5		life. Do N	OT use retired.)										
AND the hospital detached to	ed l	COMPL	12]	Bookk	eepir	ıg S						. O. (Government		
/LA	t once.	8	17. FATHER'S NAME (First, A		. 7								ddle, Maiden	Surneme)				
TARY stained by should be	ed at	BE	John J.		ad	_						Whit						
MAR retained 5 should	notified	2	Louis C.					LING ADORES								3 21701		
may be	2		200 METHOD OF DISPOSIT	TION		20h.		ATE OF DISPO			DII	OATE		CATION —		d. 21701		
ALTIMORE, leath, Page 6 may be funeral director, page	must		1 Se Buriel 2 Crematic		oval from State		etery_cremator	y or other plece				5/12				le, Md.		
ALTIMO death, Page 6 funeral directo	iner		21. SIGNATURE OF FUNERA	AL SERVICE LIC	ENSEE			22		AND ADDRES		CILITY				-07		
	examiner		Jum C	16	H					con F			. 20	838				
10 在 天色	medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between															
with hours	E		IMMEDIATE CAUSE (Fi	MMEDIATE CAUSE (Final disease or condition as April Faulus). Sequently as the condition of														
	event, the		DUE TO (OR AS A CONSEQUENCE OF):															
58760 executed with and comple or hugal cras		NO	Sequentially list conditions, b. DUE TO (OR AS A CONSEQUENCE OF).															
Clark to O	traumatic	RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING													ì		
D bys Cale		띮	cause. Enter UNDERLITING C. OUE TO (OR AS A CONSEQUENCE OF):															
	or other	FI	resulting in death) LAS	ST .	d.													
DS, P the death the attent	any injury,	CEI	PART II. Other significa	ant condition	s contributing to	death bu	ut not resul	ting in the u	nderlyi	no cause o	niven in	Part i.	24a. WAS AN	ALITOPSY	24h	WERE AUTOPSY FINDINGS		
ORDS, that the december the standard the standard standar		MEDICAL									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR	RMED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
RECORI requires that to been signed by	OWS a	ē										_	1 TYES 2	MINO		OF DEATH?		
	5 4		DID TOBACCO	O USE C	ONTRIBUTE	TO C	CAUSE	OF DEAT	TH Y	YES 🗆	NO							
	item 23	PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL				_	PLACE OF D	EATH (Ch	eck only one)					
SICIAN: The certificate h	or ite	YSI	1 - YES 2 0		HOSPITAL:	☐ ER/Outpa	ntient 3 🗆 D	OA 4 THE	R: rsing Ho	me 5 🗆 Re	sidence	6 Other	(Specify)					
으 출 설탕	2	ву Рн	27. MANNER OF ĎEATH 1 Natural 5 2 Accident	Pending Investigation	28e. DATE OF (Month, D	FINJURY Day, Year)	260	. TIME OF INJURY M	W	YES 2] NO	28d. DE\$0	RIBE HOW I	NJURY OC	CURED			
DIVISION DR ATTENDING I	5 00	ETED B	2 0 6-4-44-	Could not be determined	26e. PLACE C building.	of INJURY atc. (Speci	— At home, t	erm, atreet, fac	tory, off	ice			TION (Street or Town, Stete)		or Rurel A	oute Number,		
0 0 0 3	tem	Ę.	290. CERTIFIER CER	TIFYING PHYSI	CIAN: To the best of	my knowle	edge, death o	courred at the	time, de	te end piece	and due	to the cour	e(s) end mai	nner se ste	led			
7 70	1 1000	COMPL	onel _													and menner ee stated.		
TO THE HOSPITA TO THE FUNERA	ORTA	BE C	296. SIGNATURE AND TITLE	e of CENTURIES						29c. LICI	INSE NUI	MDEA		29d. DAT	E SIGNED	(Migsh: Clay Was)		
554	N N	0	K61	gpn			-			D	-/3	971	4	P 4	1/2	195		
			30. NAME AND A OORESS O	PERSON WH	COMPLETED CAU	SE OF OEA	ATH (ITEM 27)	(Type, Print)	2	-	410	4	T .			11 117		
			31. DATE FILED (Month, Day,	Year)	32. REGISTRA	ARIS SIGNA	ATURE A	D	2	10	W 7	21	. <i>F</i>	KED	GRI	CK MD		
			MAY 1	5 199	32. REGISTR	daval	ionhan	24										

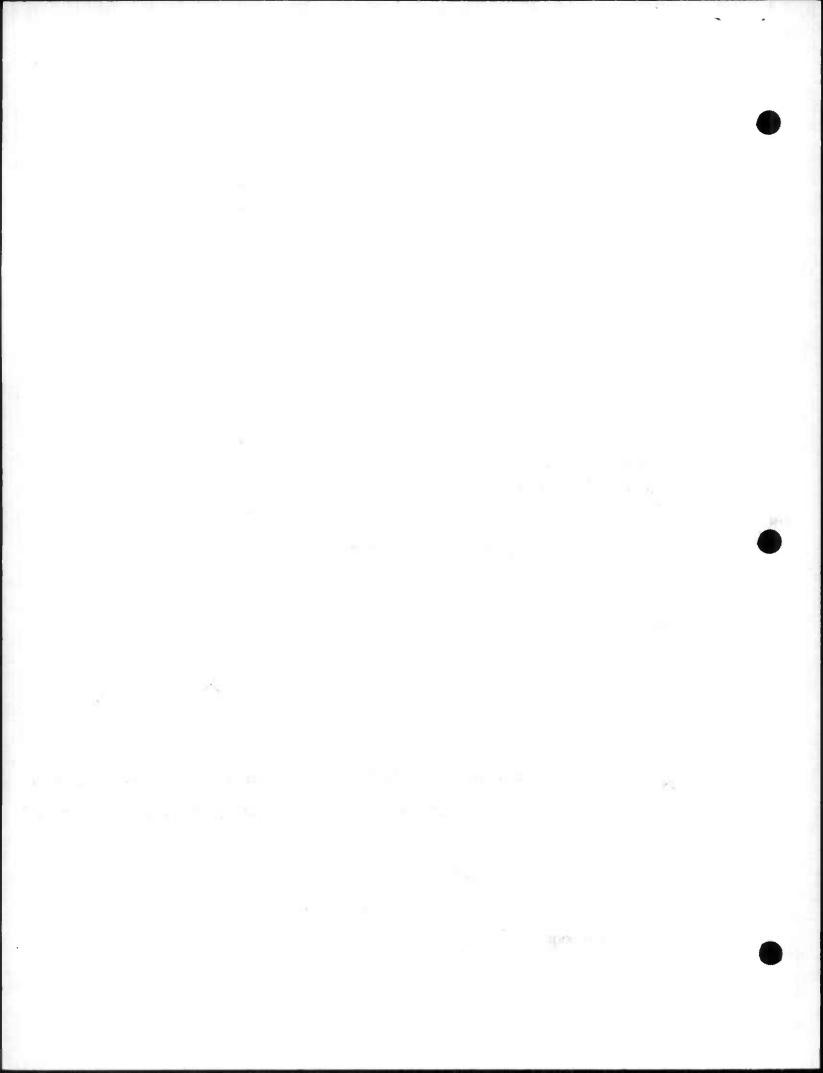


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a form of the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within #2 hours after death with the State Debt. or it health and Mental Honding Invital exemutation or exemutal.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)							2	DATE OF DEATH		T	3. TIME OF DEATH
	ERNESTO		NEUGEBA	UER		ENDTI	ZR.			MAY 8,	199	YEAR	
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs.	_	IF UNDER 1 1		IF UNDER 24 HI	is. 7.	DATE OF BIRTH	100		PLACE (State or Foreign
	125-44-9389)	1, M 2 □ F	52	YRS.	MONTHS	AYS	HOURS MI		une 11.	1942	Bra	v)
	Sa. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY, TO	O NWC	R LOCATION O				NTY OF DI	
CTOR	ROUTE#17 2	25MTL	ES SOUT	H OF	BBLE	мтг	זחנ	ETOWN			r D	וממש	TCV
5	RESIDENCE OF DEC	EDENT								FREDERICK			
HE N	Md .	10b. COUNT			10c, CITY, TOWN OR LOCATION								10d, INSIDE CITY LIMITS?
ā	100, STREET AND NUMBER		shington		Ro	hrers	_					1X YES 2 NO	
M M	4326 Main S							ZIP CODE					HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	١.	Las vas secessi				_	21779				razi	
	1 Never Married 2	Married	FORCES? 1	WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO If yes, specify Cuban, Maxican If yes, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Maxican I ☐ YES 2 ₹₹ NO. Searcity							s or No	14. RACE Black	— American Indian, , Whita, atc.
B	3 Widowed 4 X Divo	erced	IF YES, GIVE V	MAR OR DATES		1] YES	2 NO S	eclfy:			Specif	nite
0		EDENT'S EDU		16a.	DECEDENT'S	USUAL OCC	JPATIO	N		16b. KIND OF BU	SINESS/INI		inte
once.	Elementary/Secondary (0	y highest grade 0-12)		(Give kind of life, Do NOT life, Do NOT				it of working					
- F	12			owne				r		const	ructi	on	
COM	17. FATNER'S NAME (First, M							18. MOTNER'S	NAME	(First, Middle, Malden	Surname)		
711	Magnus E									ugebauer			
TO BE	19a. INFORMANT'S NAME (te Number, City or Tox			
pe n	Marcia C.								ers	ville, Mo	1. 2	1779	
TS T	20a, METHOD OF DISPOSIT 1 Durial 2 N Crematic	n 3 🗆 Ram	oval from Stata	cemetery.	CEANODATE (FDISPOSITION (No. 1)	ON (Nar	ne of	1		EATION —		
F	4 Donation, Other		MENREE	Smit	chsbur			Ory D ADDRESS OF		5/11 Sm	ithsb	urg,	Md.
튵	0/100	6	1,000							son Funer	ral H	ome	
	Mysel	2/1	WWOL	2		31 1	Ξ. :	Main S	t	Middleto	own.	Md.	21769
ry, or other traumatic event, the medical examiner must CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) s. MUTPE INDUFIES DUE TO (OR AS A CONSEQUENCE OF):												Interval Between Onset and Death
We any Inju	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 \(\triangle \tr												
	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DE	ATH YE	S I NO		UNCERT	AIN				1 PYES 2 NO
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PL	ACE OF DEAT	N (Check only	one)						
YSI	1XXES 2 NO		1 - Inpatient 2		3 🗆 DOA		Home	5 🗆 Residen	ca 6 X	Other (Specify)	ROADI	VAY	
*	27. MANNER OF DEATN 1 Netural 5	Pending	28a. DATE OF	ay, Ybar)	28b. TIM	URY	WOF		28	d. DESCRIBE NOW	NJURY OC	CURED	
	3 Accident	Investigation	5/8 M	5	073			ES 2 NO	V	IVA-, DU	10 NZ	AUTO	
28 is FED		Could not be determined	building,	F INJURY — At etc. (Specify)	YZBIT	treet, tactory,	offica		28	I. LOCATION (Street City or Town, State)	and Number	or Rural Ru	10.41 Do 4.4.1
E H	29a, CERTIFIER			-		-			16	r 17 /W	VVV	100	NVAKALMINI
= 5	(Check only		CIAN: To the bast of										and menner as stated,
O BE COM	79b. SIGNATURE AND TITLE	OT.Q	Adla	A	29c. LICENSE NUMBER O. C. M. E					► MZ	AY 9	(Month, Day, Yber) , 1995	
F	QC NAME AND ADDRESS OF PERSON WIS COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Street, Baltimore, Maryland 21201												
	31. DATE FILED (Month, Day,	2 1995	32. REGISTRA	RIS SIGNATURE	Redall								
			14										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an interpretable of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

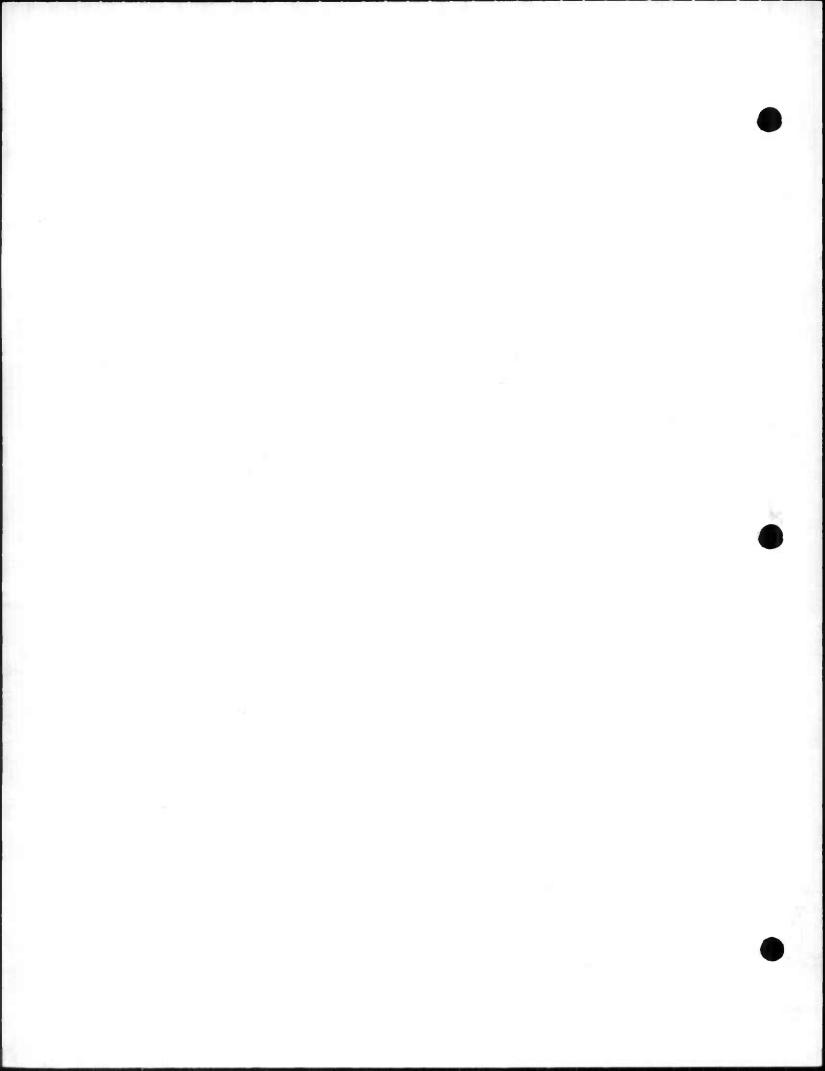
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	TIEGISTIAN		OL.		CAIL	OF	DEALL	F	IEG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	velyn Dwy	ver En	nge1k	re.			2. DATE OF MONTH May	OEATH DA	1	995"	3. TIME OF DEATH 5:45 P. M	
	4. SOCIAL SECURITY NUMBER 215-44-8429		AGE (In yrs. lest		IF UNDER 1 Y		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, Di April	BIRTH		a BIRTI	APLACE (State or Foreign	
2	90. FACILITY NAME (If not institution, give so Washington Adver		ita1		-		LOCATION OF D			9c. COU	ntgol	EATH	
5	RESIDENCE OF DECEDENT												
DIRECTOR		gomery			oma P							10d. INSIDE CITY LIMITS? XX YES 2 NO	
FUNERAL	100. STREET AND NUMBER 7525 Carroll A	venue					20912				og. CITIZEN OF WHAT COUNTRY? United States		
BY	11. MARITAL STATUS 1 Never Married 2 Merried 2 Wildowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES ZON		lf y	es, spec	NDENT OF HISPAL city Cuban, Mexico NO Specific	nn, Puerto Rica	ipecify Yee n, atc.)		14. BACI	E — American Indian, k, White, etc.	
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DEC	CEDENT'S	USUAL OCCU	JPATION	La Region	18b. KII	ID OF BUS	INESS/IN	DUSTRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) NONE	life.	omema	e retired.)	ng mosi	or working	D	omes	tic			
Ö	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NA	AME (First, Midd	le, Meiden	Surneme)			
BE (John Willia	m Dwyer					G	race			Dor	novan	
2	190. INFORMANT'S NAME (Type/Print)						d Number or Rural						
-	Judith Montanaro					ive Sil	ver Sp	ring	, Mai	rylar	nd 20903		
	20a. METHOD OF DISPOSITION 10 Donation 5 Other (Specify)	and the second	20b. PLACE A cemetery, cren	natory or ot	her place) V Memor	rial	Park 5-	DATE 11⊢1995			, Ar	wn, State Kansas	
	22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland												
	23. PART I. Enter the diseases, or	omplications that ca	used the dec	eth. Do n	ot enter th	a mode	e of dying, suc	h sa cardiac	or respi	ratory an	rest.	Approximate	
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) AS DIVATION PILLUM GIVICA DUE TO (OR AS A CONSEQUENCE OF):												
-												daye	
CERTIFICATION	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C. Cere proviscular Accident											days	
CERTIF	that initiated events resulting in death) LAST	11	AS A CONSECU		ŋ: 							/	
EDICAL (PART II. Other algnificent condition	contributing to dea	ith but not re	sulting i	n the unde	riying (ceuse given in		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE	
Σ	DID TODAGGO HGT GOVER							-1	YES 2	y no		OF DEATH?	
AN	DID TOBACCO USE CONTR	CIBUTE TO CAUS			S L NO		UNCERTAI	NX	_				
201	EXAMINER?	HOSPITAL:			OTHER:								
PHYSICIAN:	27. MANNER OF DEATH 1 Naturel 5 Pending	28e. DATE OF INJU	JRY	28b. TIME	E OF 28 URY	c. INJUR	K?	6 ☐ Other (Sp 28d, DE\$CRI		JURY OC	CURED		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF IN. building, etc.	JURY — At hon (Specify)	ne, farm, s			3 2	281. LOCATIO City or To	N (Street e	nd Number	r or Rural F	Route Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION ON 1 DESCRIPTION OF THE PHYSIC OF TH	CIAN: To the best of my I) end manner ae stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	en My	<u> </u>			2	D20	MBER 362		29d. DAT	E SIGNED	(Month, Day, Year) 7, 1995	
٥	30. NAME AND ADDRESS OF PERSON WHO NORTON EL	SON M	7 6	27 (500.	Frint) Be	elci	nest Ro	Q H	yat	Isvi	lle 1	ND 20182	
	31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE MAY 08 1995 Alia disustron for all												

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



Approximata interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

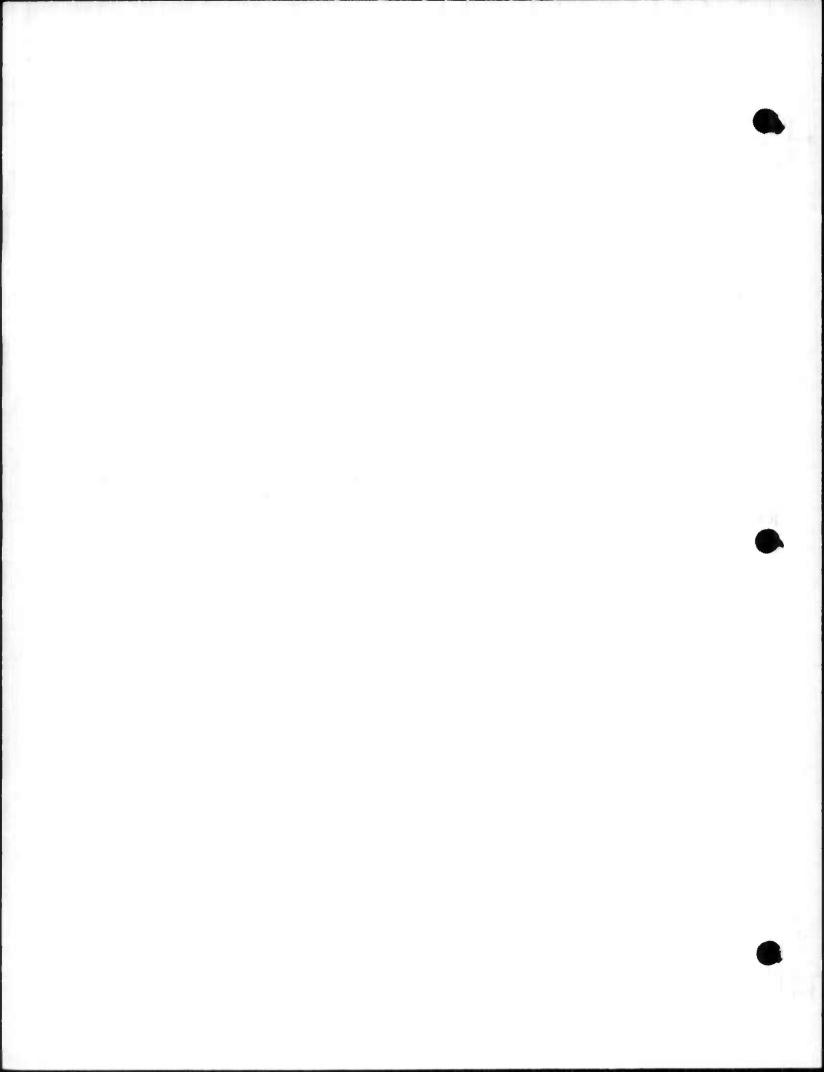
	i i	1. DECEDENT'S NAME (First, Middle, Lest) DERRYL	EA	LY					2. DATE OF DEAT MONTH MAY 1,]	. 995	YEAR	3. TIME OF DEATH
71		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea		8. BIRTNPI Country)	LACE (State or Foreign
pine		217-70-4024 9s. FACILITY NAME (If not institution, give	1 M 2 F		36 YRS.				10/14/5		Wash	
2, 3 should	OR	Prince Georges H		Center	,	96. CIT	2/	Ver /	MT			eorges
	DIRECTOR	nesidence of decedent 10a. STATE 10b. COUNT Maryland Prince	Georges				on Local Arder	TION			١,	10d, INSIDE CITY LIMITS?
020 physician. burial-transit permit. Pages 1,	FUNERAL D	10e. STREET AND NUMBER 7910 Polk Street					101	20706		10g. CITI	ZEN OF WH	YES 2 NO
e ag	B	11. MARITAL STATUS 11. Merriad 2 Merriad 13 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES :	NO NO	13.	If yes, sp		ANIC ORIGIN? (Specifican, Puarto Ricen, atc.		Black,	- American Indian, White, atc. Black
21215 al or attend for use as	9	15. DECEDENT'S EDU (Specify only highest grade		16	e. DECEDENT'S (Give kind of v	rork done	during mo	ON ast of working	16b. KIND OF	BUSINESS/IND	USTRY	
D 21 spital or hed for	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 d	·)	Salesma	e retired.)			Reta	ail		
MARYLAND retained by the hospit 5 should be detached notified at once.	BE CON	17. FATHER'S NAME (First, Middle, Last) John Quincy Ealy						18. MOTNER'S N	AME (First, Middle, Me	iden Surname)		
MARY be retained by ge 5 should b	TO B	John Q. Ealy			196 MAILING 1708	RUS	s (Street e	Avenue,	Capitol !	Town State Zip Heights	Code) , MD	20743
ALTIMORE, I death. Page 6 may be funeral director, page sxaminer must be r		29e. METHOD OF DISPOSITION A Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from State	20b.PL demote	ACE AND DATE OF	F DISPO	sition (Na	Park :	5/8/95 Su	itland	Mar	yland
death. Page tuneral di		21. SIGNATURE OF PUNERAL SERVICE LI	CENSEE			² 7	11-S	tate Full	neral Ser , NW, Was	vices,	Inc.	C. 20011
BA Filled in by the ion, or removal.		23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final	complications that List only one cau	t caused the	e deeth. Do n	ot anter	r the mo	de of dying, su	ch as cardlec or n	papiratory arr	eat,	Approximata interval Between Onset and Des
760 ed verno ompletely il, cremati event, ti		disease or condition resulting in death)	1emey	Synarol	Me		Zmo					
P.O. BOX 6876 h certificate be executed anding physician and com Hygiene prior to burial, or other traumatic ev	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CO	INSEQUENCE OF):						
DS, P.O. B he death certificate the attending phy Mental Hygiene p Njury, or other	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST										
S, ne dear the ath Menta		PART II. Other aignificant condition	ns contributing to	deeth but	not regulting i	n the u	nderlylne	Cause alven in	Part i 24e Mas	AN AUTOPSY	T 245 W	VERE AUTOPSY FINDING
RECORDS, requires that the dea seen signed by the att of Health and Merris shows any Injury,	EDICAL	Panny to peula	seemm	ry t	5 drug	re	Mi	un		FORMED?	0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
C = 5 7	N. M	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF I	DEATH YE	S 🔲	NO D	UNCERTAI	N D		1	YES 2 NO
OF VITAL RE PHYSICIAN: The law requires certificate has been with the State Dept. of rked, or Item 23 sho	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26.	PLACE OF DEAT		only one)					
OF V PHYSICIAN this certificant with the S ked, or	\	1 YES 2 NO 27. MANNER OF DEATH	1 Coppetient 2 28a. DATE OF		nt 3 🗆 DOA		28c. INJ		6 Other (Specify) 26d. DESCRIBE NO	W IN IURY OCC	TIREO	
ON OP DING PHYS After this of death with s marked,	BY P	Natural 5 Pending Investigation	(Month, De	ay, Year)	INJ		1 🗌 Y	RK?	Now. DEGOTION INC	W MISONT CCC	UNED	
ISIC TTEND TOR: A after d	ETED 8	3 Suicide 8 Could not be determined	28a. PLACE Of building,	F INJURY — i atc. (Specify)	At home, ferm, s	treet, fac	tory, office		28f. LOCATION (Str. City or Town, S	eet end Number late)	or Rural Rou	te Number,
	COMPLE	290. CERTIFIER Chock only 2 MEDICAL EXAMINE							to the cause(e) end			and manner ee stated.
THE HOSPITAL THE FUNERAL Filed within 72	BE C	290. SIGNATURE AND TITLE OF CERTIFIES						29c. LICENSE NU	MBER			Anth, Day, Viger)

Julia Dandson Bardall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

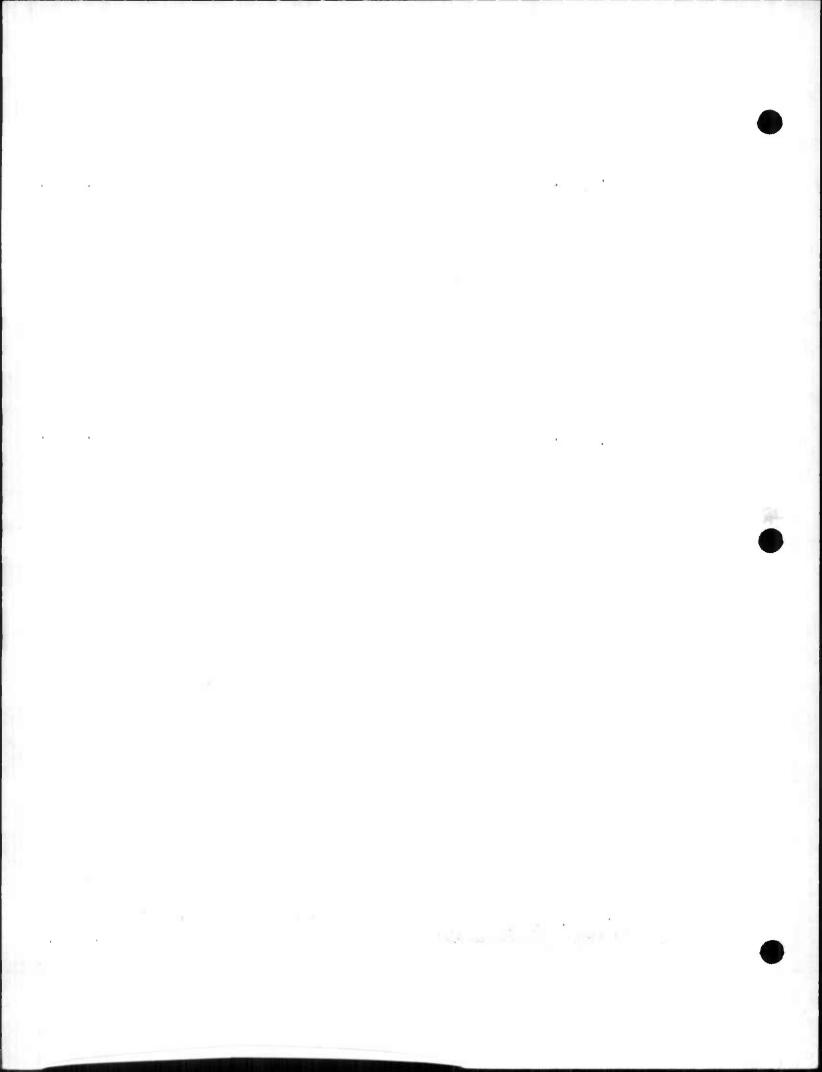


DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the nospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, centarional.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, II, 27, PER MEO FILM G-724 6/13/95 t.t

	1 - STATE REGISTRAR	SIAIE UF W	IAKYLAND / CE				DEAT		MENTA	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH
	MARY EI	IZABET	TH		EICH	IER			MAY	03.1		YEAR	11:30 A M
		. SEX	8. AGE (In yrs. last		IF UNDER		IF UNDER		7. DATE	OF BIRTH h, Day, Year)			LACE (State or Foreign
		☐ M 2大大F	38	YRS.	WONTHS	DAYS	HOURS	MIN.	Sept	13,	1956		ssouri
~	9e. FACILITY NAME (If not institution, give street	end number)			9b. CITY	, TOWN C	R LOCATIO	ON OF DE	ATH		9c. COUN	TY OF DE	ATH
Ö	1542 PATUXENT MA	NOR RI)		Da	vids	sonvi	.11e			ANNE	AR	UNDEL
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY
급	Maryland Anne A	runde1			Davi	dsor	vill	e					LIMITS?
AL	10e. STREET AND NUMBER					101	ZIP CODE				10g. CITIZ		IAT COUNTRY?
Ē	1542 Patuxent Man	or Rd.					210	35			Uni	ted S	States
FUNERAL	11. MARITAL STATUS 12 1 X Never Married 2 Merried	FORCES? 1	EVER IN U.S. ARM	ED						17 (Specify Yes	or No-	14. RACE -	- American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES				2 (T) NO			ricon, etc.)		Specify	
	15. DECEDENT'S EDUCATI	ION	16e DEC	FOENT'S	USUAL O	CCLIBATIC	·M		1 404	, KIND OF BUS	PINESS (INDI	IOTOV	willte
	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5 +	(Give	kind of			st of workin	g	100	KIND OF BU	SIRESS/INDC	SIRT	
립	continuity (oriz)	4		itor						Commun	ity Ne	ews	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAI		Middle, Meiden			
BE (Albert Hull Eic	her					He	len.	Betl	Chear	tham		
6	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	S (Street e	nd Number	or Rural F	loute Num	ber, City or Tow	n, State, Zip i	Code)	
	Mary Eicher Cole		1	Pic	ardy	Lar	ne S	t. I	ouis	Mo.	53124		
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal	from State	20b. PLACE AP cemetery, crem	atory or o	ther place)				OAT		CATION — C		1994
- 1	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS	REF	Metro	poli	tan		nator D ADDRES			1	Alexar	ndria	a Virginia
			Pres		ı"F	lobe	t E.	Eva	ins I	unera:	1 Home	e, P.	.A.
			. , ,		1	6000) Ann	apo1	is E	Rd. Boy	wie Mo	1. 20	
	23. PART I. Enter the disesses, or com shock, or heert failure. List	plicetions thet t only one ceu	ceused the dee se on each line.	th. Do r	ot enter	the mo	de of dyl	ng, such	ss cere	diec or respi	retory srre	st,	Approximete interval Between
	disease or condition CARDIAC ARRHYTHMIA												Onest and Death
												-	
_			IAL NECROS		,								
<u> </u>	Sequentially list conditions, if any, leading to immediate	OUE TO	OR AS A CONSEQU	ENCE O	7):								
CA	CAUSE (Disesse or injury												
E	that initisted events resulting in death) LAST	OUE TO (OR AS A CONSECU	ENCE OF	7:								
CERTIFICATION	d			31									
CAL	PART II. Other significant conditions c	ontributing to	deeth but not re	uiting	n the un	derlying	ceuse g	iven in i	Part I.	24a. WAS AN			VERE AUTOPSY FINDINGS
200	MULTIPLE SCLEROSIS					_				PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI											D		OF DEATH?
	DID TOBACCO USE CONTRIB	UTE TO CAL	JSE OF DEAT	H YE	S 🗆 I	10 D	UNC	ERTAIN	<u>-</u>				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE	OF DEAT									
YSI	1)X) YES 2 □ NO	Inpetient 2 🗆	ER/Outpetient 3	DOA	4 Nur		5 Pe	sidence (6 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH 1)(X) Netural 5 Pending	28e. OATE OF (Month, Da		28b. TIM INJ	E OF URY	28c. INJU WO	RK?		28d. DES	CRIBE HOW II	NJURY OCCU	JRED	
B	2 Accident Investigation				М		ES 2	NO					
ED	3 Suicide 6 Could not be determined	building, o	INJURY — At homete. (Specify)	e, farm, e	treet, fact	ory, office			281. LOC City	ATION (Street e or Town, State)	nd Number o	r Rural Roo	ute Number,
9	290, CERTIFIER												
COMPLET	(Check only 1 CERTIFYING PHYSICIAN One) 2 MEDICAL EXAMINER: 0												
8	296. SIGNATURE AND TITLA OF CERTIFIER	1	TIBITATION AND OF WA	wattgatto	n, in my o	pinion, oi				end place, en	d due to the	ceuse(e) a	and manner es stated.
BE	MAN A HELAN					- 1	29c. LICE		BER	ļ			Aonth, Day, Year)
2	SO. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CALLS	OF DEATH (ITEM	27) (Type	Print)		00	CME			MA	Y 04	1,1995
	MARIO = GOLLE	TR	1410			Str	eet	Ra	1+1	more	Mar	w l ar	nd 21201
	31. DATE FILED (Month, Day, Year) MAY 22 1995	32. REGISTRAF	I'S SIQUATURE		J1111	J (1		, ве	. L L L	more,	rat	утаг	IG 21201



Pages 1, 2, 3 should

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AZ	RA	27	11 3
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remova	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
EH	E F	× p	FE
E	E	File	P
2	2	2	=

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY VEAR ANNA KARPOOK EVANUSA May 1995 1325 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 K F 213-50-6235 15. May 1913 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CTR SALISBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND SOMERSET PRINCESS ANNE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 12741 EAST RIDGE ROAD 21853 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 🔀 Widowed 4 🗌 Divorced Specify WHITE ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SIMON KARPOOK BE MARY KARPOOK 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 MR RICHARD EVANUSA ROAD. **PRINCESS** ANNE MD 21853 20a. METHOD OF DISPOSITION

Surial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Andrews Russian Orthodox Cem. 5/6 Donation 5 Other (Specify) BALTIMORE. MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME, M00295 PRINCESS ANNE MD 21853 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. intervai Between IMMEDIATE CAUSE (Final Onset and Death fers laterace bue to (or as a consequence of): disease or condition Pateral MI reaulting in death) hour CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE DF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 DENO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO OTHER ng Home 5 🗆 Rasidenca 8 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation M 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

5-5-95 4 2521 2 30. NAME AND ADDRESS OF PERSON AND COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 30434 mt Vernonk rarles Steaman DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Julia Dandine Rall 08 1995

Andrew Comments of the Comment

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. NO.		
8	1. DECEDENT'S NAME (First, Middle, Last) Arthur G. Es	worthy				2. DATE OF DEATH MONTH DA		
	4. SOCIAL SECURITY NUMBER		iE (In yrs. lest birthdey)	IF UNDER 1 YEAR		May 1		
	578-12-5327	10 MADE		NONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Jan 31, 1	917 MAR	RTHPLACE (State or Foreign Units) YLAND
	9a. FACILITY NAME (If not institution, give :	street and number)		96. CITY, TOWN	OR LOCATION OF DE		Sc. COUNTY OF	
TOR	WASHINGTON ADVENT	TIST HOSPITA		TAKOMA			MONTGO	
DIRECTOR		EDERICK	FREI	TOWN OR LOCA			-	10d. INSIDE CITY LINIDS? 1 YES 2 NO
FUNERAL	9614 HALL RD.			101	2170	1	10g. CITIZEN O	F WHAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED			C ORIGIN? (Specify Yes	ov No 14 B	ACE — American Indian
B	1 Never Married 2 Married 3 Widowed Married	FORCES? 1 TYPES GIVE WAR OF		If yes, sp	ecify Cuban, Mexican 2 NO Specify:	, Puerto Rican, etc.)	В	ACE — American Indian, leck, White, etc. HITE
0	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S U	SUAL OCCUPATION	ON .	16b. KIND OF BUS	INESS/INDUSTR	1
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	MANAGER	rk done during mo retired.)	st or working	AUTO	MOTIVE	DEPT.
CO	17. FATHER'S NAME (First, Middle, Last) ALBERT ESWORTHY					RE (First, Middle, Maiden E ALDRIDGE		
H	19a. INFORMANT'S NAME (Type/Print)							
2	LORRAINE K. ESWOF	RTHY	9614 HA			oute Number, City or Town EDERICK	n, State, Zip Code) M	
	20e. METHOD OF DISPOSITION BUT 1 Burlet 2 Cremation 3 mem 4 Donation 5 Other (Specify)	CLAL pyel from State	Ob. PLACE AND DATE OF	DISPOSITION (NE	IETERY		CATION — City or	Town, State IRY, MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSES	Pen	22. NAME AF		YTOWN, MD	HARTZLE	R & SONS
	23. PART I. Enter the diseases, or	complications that care	ed the death. Do no	t enter the mo	de of dving, auch	as cerdiec or reani	ratory arrest	Approximate
	ahock, or heart fellure. IMMEDIATE CAUSE (Final	List only one cause or	eech line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	an octored of reapi	atory arrest,	Interval Between Onsef and Death
	disease or condition resulting in death)	. Car	discourse	11.	ch			01/ .
		DUE TO (OR A	disperse s a confedence of:	- AUG				2/2 does
NO	Sequentially list conditions,	LUL OS	A CONSEQUENCE OF	spect	con			22 days
CAT	If any, leading to immediate cause. Enter UNDERLYING	202.10 (0.1.7.	on consequence or ,					
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR A	S A CONSEQUENCE OF):					
H	resulting in deeth) LAST	d						
	PART II. Other significant condition	ne contributing to death	but not reaulting in	the underlying	cause given in F	Part I. 24e. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
MEDICAL						PERFOR		AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
ME						_		1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE			UNCERTAIN			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)				
14S	1 VES 2 NO	1 Impatient 2 ER/O	utpatient 3 DOA 4	☐ Nursing Hom	e 5 🗆 Residence 6			
	1 Natural 5 Pending	(Month, Day, Year		WO WO	RK?	28d. DESCRIBE HOW IN	JURY OCCURED	
D BY	3 Suicide 8 Could not be	28e. PLACE OF INJU- building, etc. (S	RY — At home, farm, str	eet, factory, office	-	28f. LOCATION (Street a City or Town, State)	nd Number or Run	al Route Number,
ETE	4 Homicide determined					Oily or Iowii, State)		
COMPLET		CIAN: To the best of my kn						
S I	2 MEDICAL EXAMINE	R: On the basis of exemina	tion and/or investigation,	in my opinion, d	eath occured at the ti	lme, data and place, and	dua to the caus	e(s) and manner as stated.
BE	396. SIGNATURE AND TITLE OF BERTSFIELD	1			29c. LICENSE NUME	BER	29d. DATE WILL	ED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON	TO DI EVEN CAUSE CO	DEATH ATTACA		D28883		9//	0/95
	Da	PLETED CAUSE OF	BEATH (ITEM 27) (Type, P	nnt)	-11	0		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE	UG. 11	Kama	ack m	2091	2
	MAY 1 2 1995 July	a Seveleor Rev	lall					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

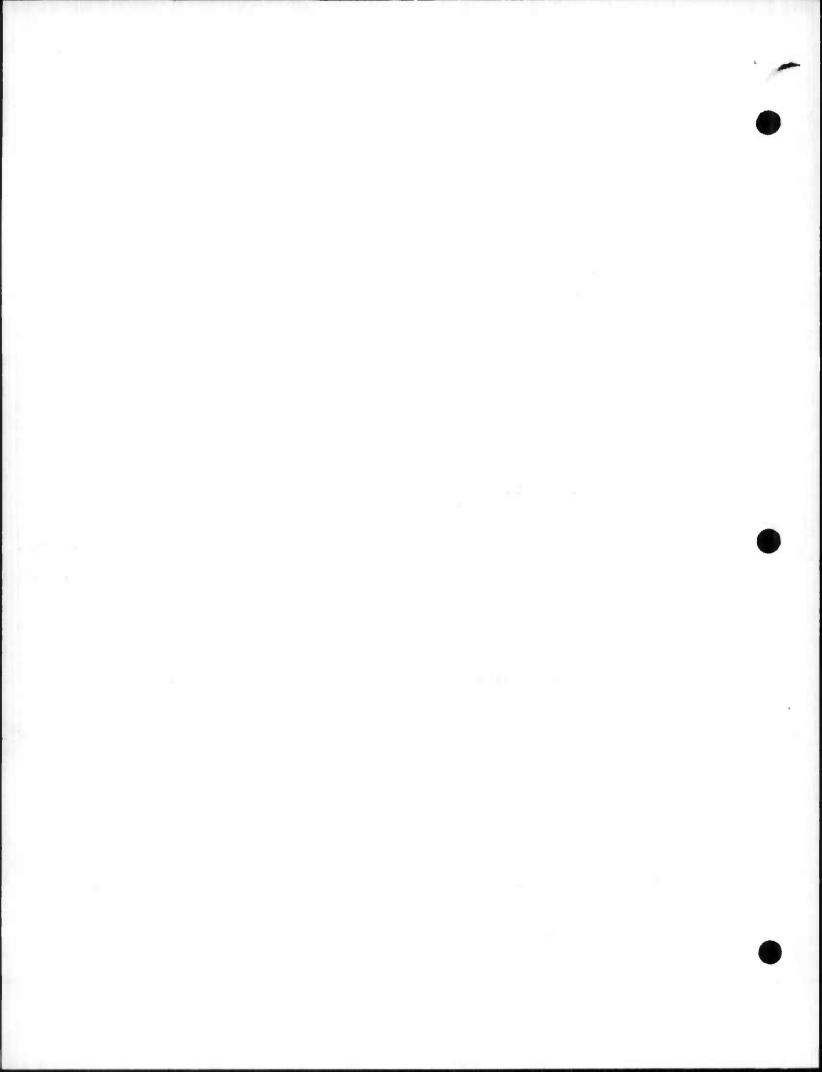
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Degr. of Health and Mental Hygiene prior to burial, certainfoil, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

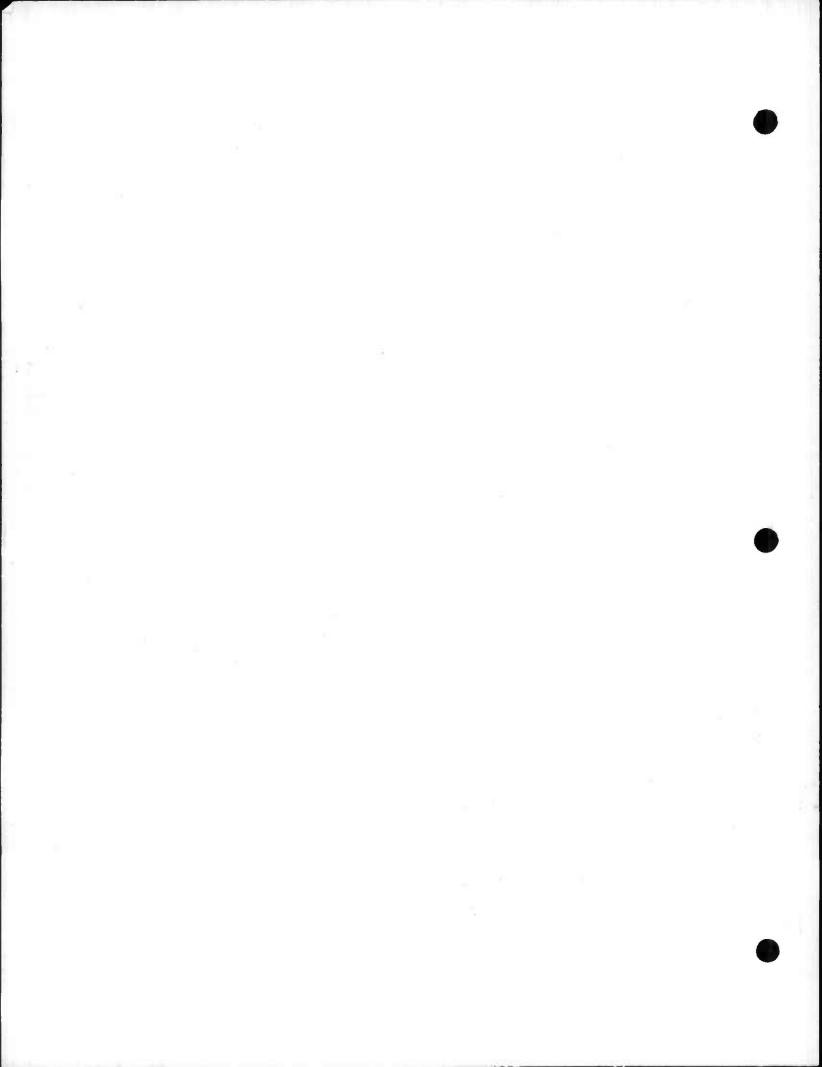
	1. DECEDENT'S NAME (First,	4.4.4.4. 4 A		_	OLITIII	IOATI	. 01	DLA	111	HEG. NO).			
	Katherine	Herm		d						2. DATE OF DEATH MONTH MONTH 12, 1	995	YEAR	3. TIME OF DEATH 7:00 A M	
	4. SOCIAL SECURITY NUMBER 214-22-949	-	5. SEX		s. lest birthday) 9 0 YRS.	#F UNDER	DAYS	#F UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 7,	1904	Countr	PLACE (State or Foreign y) 'Vland	
	9a. FACILITY NAME (If not ins	titution, give st	reet and number)			9b. CITY	, TOWN C	R LOCATI	ON OF DE			NTY OF D	4	
DIRECTOR	Westminster	Nursin	ng/Conval	escen	t Ctr.	We	estm:	inste	er		Cau	roll		
E	10a. STATE	10b. COUNTY			10c, CIT	Y, TOWN O	OR LOCAT	ION					10d. INSIDE CITY	
	Maryland 100. STREET AND NUMBER		rroll			Westr							1 YES 2 NO	
FUNERAL	Westminster	Nsg/Co	4 Washing onv. Ctr	gton Re	oad		101	21 ZIP CODI	zip code 10g. citizen of what country? 21157 United States					
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S	. ARMED	13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify Ye		14. BACE	- American Indian.	
BY	1 Never Married 2 1 9 3 Widowed 4 Divor	- 1	IF YES, GIVE W			MNO If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:						Specif	i, White, etc. ly: ite	
ED	15. DECE	DENT'S EDUC	CATION COMPONENTS	164	DECEDENT'S					16b. KIND OF BU	SINESS/IN			
COMPLET	Elementary/Secondary (0-		College (1-4 or 5 +)	(Give kind of life. Do NOT u	work done is retired.)	during mo:	st of workin	g					
P.	10				PBX O	perat	cor			Depa	rtmer	nt St	ore	
Ö	17. FATHER'S NAME (First, Mic	ddle, Last)						to. MOTI	IER'S NAM	ME (First, Middle, Malder	Sumame)			
BE	Walter Brewe	er						Ar	na W	lolfe				
	19a. INFORMANT'S NAME (19)	pe/Print)			19b. MAJLING	ADDRESS	(Street a	nd Number	or Rural A	loute Number, City or Tox	vn, State, Zij	Code)		
임	David L. For	ď								patowne,				
	20a. METHOD OF DISPOSITIO			20b. PL/	CEANDDATE	OF DISPOS	ITION /Na	me of		DATE 20c. LO	OCATION —			
	4 Donation 5 Other		rvai from Stata	Lake	cremetory or o	ther place) Temor	cial	Gard	lens	5/15 E1d	ersbu	ira,	Maryland	
	21. SIGNATURE OF FUNERAL	SERVICE LICE	ENSEE	,	av =			D ADDRES		HLITY				
	Sugar	WX	laher	WM	ueso	9]	Wil	llis	Stre	Home et, Westm	inste	er, M	D 21157	
	23. PART I. Enter the dis shock, or he	eases, or co	omplications that list only one cau	calcaged the	death. Do	not enter	the mo	de of dyl	ng, auch	as cerdiec or reap	iratory ar	reat,	Approximate	
	IMMEDIATE CAUSE (Fina												Interval Between Onset and Death	
	disease or condition resulting in death)	> ,	P	elmo	NSEQUENCE P	19	200	em	-				7 hours.	
	inger inger to think					+		_					7 hours.	
N	Sequentially list condition	D 6		zv									> 15yr	
Ĕ	if any, leading to immedi	late	DUE TO	OR AS A CO	NSEQUENCE O	F):								
CERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disease or injury													
E	that initiated events resulting in death) LAST		DUE 10	OR AS A COP	NSEQUENCE OF	F):								
8		d												
	PART II. Other significen	t conditions	contributing to	death but n	ot resulting	in the un	derlying	cause g	iven in F			24b.	WERE AUTOPSY FINDINGS	
걸	[2.	artin	nsen 14h	15 4						PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL											(E-mir		OF DEATH?	
	DID TOBACCO US	E CONTR	IBUTE TO CA	USE OF D	EATH YE	S 🗆 1	NO 🗆	UNC	ERTAIN	1 121				
X	25. WAS CASE REFERRED TO				PLACE OF DEAT									
Sign	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outpatien	it 3 □ DOA	OTHER		5 🗆 Re	aldence f	B Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF		28b. TIM	E OF	28c. INJU	JRY AT		26d. DESCRIBE HOW	INJURY OC	CURED		
ВУ	1 Natural 5 P	ending restigation	(Month, Da	ry, rear)	1943	URY M	1 📋 Y	ES 2	NO					
	3 Suleido —	ould not be	28e. PLACE OF	INJURY - A	t home, ferm, s	treet, fect	ory, office			261. LOCATION (Street	and Number	or Rural R	oute Number,	
3 Suicide 8 Could not be determined 281. LOCATION (Street and Number or Rural Route M City or Town, State) 281. LOCATION (Street and Number or Rural Route M City or Town, State) 282. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.														
2	29e. CERTIFIER (Check only	FYINO PHYSIC	IAN: To the best of	my knowledge	, death occurre	d at the ti	me, data	and place.	and due I	to the cause(e) end ma	nner as stat	led.		
8													and manner se stated.	
	296, SIGNATURE AND TITLE C							29c. LICE					(Month, Day, Year)	
BE	Willem	ROS	? and	2	mn		İ	N	7 0	389			2/95	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type,	Print)		0	7	20/		, , , ,	-1 12	
	William R. O	'Rourk					reet	, We	stmi	nster. MD	211	57		
	William R. O'Rourke M.D. 150 West Main Street, Westminster, MD 21157													
	MAY 1 5 1995 July d'Author harvall													



		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	ENTAL HYGIENE
	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
0	ECEDENT'S NAME (First, Middle, Last)	9	DATE OF DEATH

	Γ		4 DECEMBER 11 MARKET CO.	*****					IOATI		DEA	-		3. NU.			
			1. DECEDENT'S NAME (First,			. 1							2. DATE OF DE MONTH	DAY	YEAR	3. TIME OF DEATH	4
			4. SOCIAL SECURITY NUMBER	wilb	5. SEX	url							MAY	05	1995	12:20	PM
					1 🔀 M 2 🗆 F	0. AGE	(In yrs. lest	YRS.	IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF BIR (Month, Day,	Year)	Coun	HPLACE (State or Fore	ьign
pin			577-09-2498				_77	THS.					May 15			ryland	
3 should		œ					_				OR LOCATIO	ON OF DE	EATH	9c. C	COUNTY OF	DEATH	
2,		CTOR	Shady Grove	e Adve	ntist Ho	spit	al		Re	ockv	ille				Montg	omery	
Pages		Ä	10a. STATE	10b. COUNTY	7			10c. CIT	Y, TOWN	OR LOCA	TION		-			10d. INSIDE CITY	
~		DIRE	Maryland	Mon	tgomery			G	aith	ersb	ourg					LIMITS?	NO
permit.		A	100. STREET AND NUMBER							7	H. ZIP CODE			109.	CITIZEN OF	WHAT COUNTRY?	
n. ansit		E	207 Meado	wgate	Terrace						20	877		Uı	nited	States	
020 physician. burlal-transit		FUN	11. MARITAL STATUS		12. WAS DECEDEN								VIC ORIGIN? (Spe	offy Yes or No-	- 14. RAC	CE — American Indien	n,
21215-0020 of or attending physician, for use as the burial-tran		BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR D	ATES	~			S 2 X NO		n, Puerto Rican, a y:	rc.) ~ _{0.4}	Spe		_ 3
15- endin				EDENT'S EDU	World W	ar I					-				1	White	
or aft		ETE	(Specify only	y highest grade	completed)		(Gh	ve kind of a Do NOT us	WORK done	during me	ost of working	g	16b. KIND	OF BUSINESS	INDUSTRY	3	1
of by		_	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)				o T	aahna	1001	ot Noti	0001 1	2.12001	of Stan	dond
AND the hospital detached to	nce.	COMP	17. FATHER'S NAME (First, M.	liddle, Lest)			THO	Logi	agiii	C 10			ME (First, Middle,			1 OI Stall	dard
Z & Z	H O	- 1	_	sic	Furlo	17.7					10. 110		Ida		ampbe]	1 7	
MAR retained 5 should	notified	BE	19a. INFORMANT'S NAME (7)		Tulle	7 44	196	MAILING	ADDRESS	(Street	end Number	or Rural I	Route Number, City			1.1	
5 5 0		임	Ann M. Ro	berts			- 1									20877	
W > 2	90		200. METHOD OF DISPOSITI		L. I. IRC	20b	. PLACE A	NDDATE	OF DISPOS	ITION /N	ame of			Oc. LOCATION			
- w =	must	ĺ	1X Burlal 2 ☐ Crematio 4 ☐ Donation 6 ☐ Other		oval from State	– Ga	netery, crem	f He	ther placa)	Cer	meter	V	5/9	ilver	Spri	ng, Maryl	and
	examiner	4	21 SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE		50 1	1					CILITY				
ALTI death. P	жаш		DeVol Funeral Home														
after by the			23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate interval Between														
Mours of in	medical		Interval Between Onset and Death														
by filled ation, o	-	1	disease or condition resulting in death) a. Inclusional														
with with plete	event,																
687 ecuted nd con burial.		z	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):														
× 5 5 2		ERTIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A	CONSEQ	ENCE O	F): /	2	and the contract of the contra		77 6	Rever	1		
	r tr	<u>র</u> ∥	CAUSE (Disease or Inju		c 14	400	260	all	in	M	such	u	with	RIELL	ula	es	
certificate ding physi	othe	비별	thet initiated events resulting in death) LAS		DUE TO	OR AS A	CONSEO	UENCE OI	F):	1		10	. Ada				
O E 5 5	7. 0	뜅			s	121	o ay	Spe	as	120		de	a al				
2 4 2	5 1	11	PART II. Other significe	nt condition	a contributing to	deeth b	ut not re	sulting	in the ur	derlyln	g cause g	iven in		AS AN AUTOP	SY 24	b. WERE AUTOPSY FINE	
D & 8 E	36	EDICAL												ERFORMED?		AMAILABLE PRIOR TO COMPLETION OF CA	
puires the signed Health a	S	ME											_	20 2 34 110		OF DEATH?	, 1
AL RECO	23 sh	ž	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE O	F DEAT	H YE	S 🔲 I	NO [UNC	ERTAIN	10				·
Q 9 2 0	Item 2	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	WOODITAL		26. PLACE										
SICIAN: The Certificate the State	or It	XSI	1 TYES 2 NO		HOSPITAL:	ER/Outp	sitient 3	□ DOA	OTHER		ne 5 🗆 Red	eldence	6 Other (Speci	fy)			
PHYSICIAN: this certifica	ed.	표	27. MANNER OF DEATH		28e. DATE OF (Month, D			28b. TIM	E OF URY	28c. INJ WC	JURY AT		28d. DESCRIBE	HOW INJURY	OCCURED		\neg
DING PI After th		à		Pending investigation					М		YES 2	NO					
OR ATTENDING IN DIRECTOR: After Hours after death	.00			Could not be	28e. PLACE O building,	etc. (Spec	— At hon	ne, farm, s	treet, fect	ory, offic	28		281. LOCATION (Street and Nurr State)	iber or Rural	Route Number,	
OR ATTENDING DIRECTOR: After hours after death	m 28	LETEI															
	If item	MPL			CIAN: To the best of												
HOSPITAL FUNERAL within 72	N.	8	2° MEDI	CAL EXAMINE	R: On the besle of s	xamination	n end/or in	oitsgitsevi	n, in my o	pinion, d	death occure	d at the	time, date end pl	ice, end due t	o the ceuse(e) end manner ee stat	ted.
THE H	PORTANT	BE	29h. SIGNATURE AND TITLE	OF CERTIFIER	5 -110)			_		29c. LICE	NSE NUM	IBER	29d. (DATE SIGNED	(Month, Day, Year)	\neg
0 0 0		2	Xili	100	al ll	211		20	26)			2.	3/10	P1	MAY	05 199	15
1		-	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETEO CAU	SE OF DE	ATH (ITEM) /	2 1 1	4.			
1		-	GITA 13	AKSI	11 9	406	0/1	06	cor	90-1	-OWN	UK	d. Be	thes o	LOSM	D. 201	874
1 /			31. DATE FILED (Month, Dey, 1	0	32. REGISTRA	A'S SIGN	ATURE			1					and the second		
	L		MAY 1	() 1995	Juliad	auch	or Ren	dalle									

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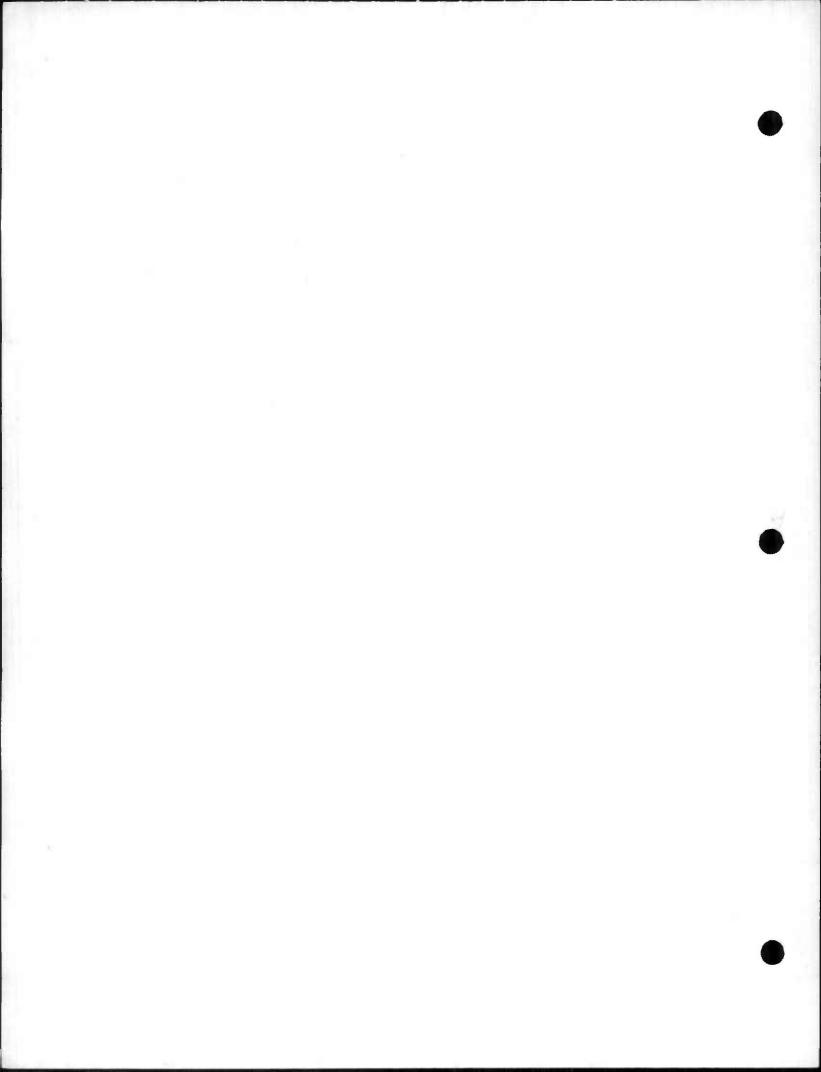


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL	HYGIENI REG. NO.	E			
18	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH		3	. TIME OF DE	ATH
	A	nthony S. Fr	azier			Apri	1 15,		EAR	12:50	РМ
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	-	BIRTHPL	ACE (State or	
	None	1 XM 2 - F	- YRS.	ONTHS DAYS	2 55		Day, Year)	1995	Country)	land	
	9e. FACILITY NAME (If not institution, give s	treet and number)	9	b. CITY, TOWN C	R LOCATION OF D			9c. COUNT			
DIRECTOR	Holy Cross Hospit	:a1		Silve	r Sprinc	1		Mon	tgom	erv	
딥	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	7	Me CITY 1	TOWN OR LOCAT					-		
E	Maryland M	lontgomery	100.0111,1							od. INSIDE CIT	
	10e. STREET AND NUMBER	onegomery		- V	ington ZIP CODE			10a CITIZE		T COUNTRY?	
FUNERAL	10105 Crestwood R	load			20895					States	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER I	U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	(Specify Yes			- American Inc	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 K NO	If yes, spe	city Cuben, Mexica 2 NO Specifi	in, Puerto Ric			Black, 1 Specify:	White, etc.	
										Bl	ack
国	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of work	k done during mos		16b. K	IND OF BUS	INESS/INOUS	TRY		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)							
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)		None		18. MOTHER'S NA	100 000 100	Non				
	Tony Robert Mi	tchell Frazi	or			la M.		- 1			
BE	19a. INFORMANT'S NAME (Type/Print)	CLIII , State, Zip Co	v/fe)								
2	Angela M. Frazier				od Road,				,	80¢ 5n	95
- 1	20a. METHOD OF DISPOSITION	206	PLACE AND DATE OF Control of the Property of t					ATION — CH			22
	1 Donation 6 Other (Specify)	oval from State Cen	etery, cremetory or other ontgomery	Cremat	orium, i	nc.	Beti	hesda	Mai	ryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE ()		22. NAME AN	D ADDRESS OF FA	CILITY RO	hert i	A Dim	nhr	or Fun	eral
	MIRATO S	1 doilla	M00348	mone/ b	ethesda- nsin Ave	cnevy	unase	e, inc		1551	
	23. PART I. Enter the diseases, or c	complications that caused	the death. Do not							Approxir	nata
	ahock, or heart fallure. I IMMEDIATE CAUSE (Final	Liat only one cause on e	och line.					1200		Interval I	Between
	disease or condition resulting in death)	Extri	consequence of:	matru	eta						15.
	Touching in County	DUE TO (OR AS A	CONSEQUENCE OF):								
۲	Sequentially list conditions,	b								1	
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								
윤	CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE OF):						_	-	
CERTIFICATION	that initiated events resulting in death) LAST		0,7								
- 1										+	
K	PART II. Other significant conditions	a contributing to daeth b	ut not resulting in t	the underlying	cause given in	Part I. 2	4a. WAS AN A PERFORM			ERE AUTOPSY MILABLE PRIOR	
ă						_ [1	☐ YES 2 (NO	C	OMPLETION OF F DEATH?	
¥									1	TYES 2 X	NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR				UNCERTAIN	4 🗆					
ত 당	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO	HOSPITAL:	26. PLACE OF DEATH (THER:	-						-
¥	27. MANNER OF DEATH	1 Sonpatient 2 ☐ ER/Outp	28b, TIME O		5 Residence			#10V 0.00V	-		
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	Y WO		266. DESCH	IIRE HOW IN	JURY OCCUP	IED		- 1
) BY	2 Accident Investigation 3 Suicide s Could not be	28e. PLACE OF INJURY	— At home, ferm, stree		20 2 110	28f, LOCATI	ON (Street en	nd Number or	Rumi Roui	te Number	-
	4 Homicide determined	building, etc. (Spec	lly)			City or	Town, Stete)				
빌	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	edge, death occurred a	t the time date	and place, and due	to the cause	(a) and mann	or an atalod			
COMPLETED		R: On the basis of examination							euse(e) ei	nd manner as	stated.
	296. SIGNATURE AND TITLE OF CENTIFIES				29c. LICENSE NUN					onth, Day, Year	
BE	A. LA	dollersmo	-			5369		> 4	1/15	195	
2	30. NAME AND ADDRESS OF EERSON WHO								/ /	, –	
ĺ	Hlan Goldber	9, MD	1500 Fore	st Gler	Rd.	Silver	Spri	ngin	1D 2	0910	
	31. DATE FILED (Month, Pay, Year)	32. REGISTRAR'S SIGN.	ATURE					U			
	MAY 11 199	June amon	ax varous								



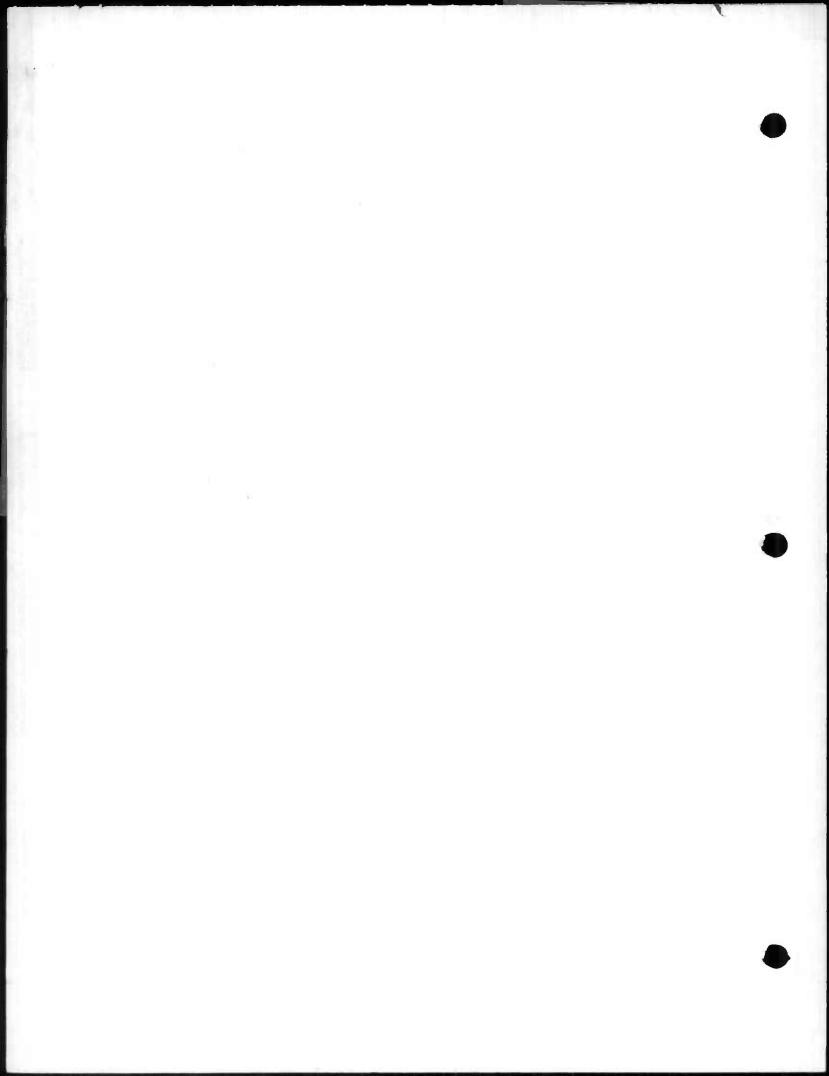
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	hat the death certificate be executed within 24 hours after death. Pa
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, or hours after death. Page 6 may be retained by the hospital or attending physician.

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		1 - STATE REGISTRAR	STATE OF I			TMENT OF ICATE OF	HEALTH AND	MENTA	L HYGIEN					
Γ		1. DECEDENT'S NAME (First, Middle, Last)				JOANE OF	DEATH	2. DATE	OF DEATH		3.	TIME OF DEA	TH	
		Ethyl Bobby	Fratta	li				MONT		1995	YEAR	3:43	Δ м	
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE	OF BIETTH			ACE (State or f	oreian	
		218-38-8569	1 🗌 M 2 🔀 F	83	YRS.	MONTHS DAYS	HOURS MIN.		t. 17,	1911	Penn	sylvar		
	OB	•a. FACILITY NAME (If not institution, give s Montgomery Gener		tal		01ney	OR LOCATION OF D	DEATH		9c. COUNT	y of DEAT			
	딥	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	1		Inc CIT	Y. TOWN OR LOC	ATION				140	d. INSIDE CIT		
	DIRECTOR		ntgomery		7.554	lver Sp						LIMITS?		
	RAL	100. STREET AND NUMBER 2700 Emmet Road	ı			,	0f. ZIP CODE 20902			10g. CITIZE		AT COUNTRY?		
ľ	FUNER,	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	ARMED	13 WAS DE	CENDENT OF HISPA	NIC ORIGI	17 /Engelfy Vo			- American Ind	lla-a	
	B	1 Never Married 2 Married 3 Widowed 4 Divorced		YES 2		If yes, s	pecify Cuben, Mexic S 2 XNO Speci	an, Puerto	Rican, etc.)	or No.	Black, V	White	ien,	
- 1		15. DECEDENT'S EDUC (Specify only highest grade			(Glum brind of w	USUAL OCCUPAT	TION	168	. KIND OF BU	SINESS/INDU	STRY			
	Ē	Elementary/Secondary (0-12)	College (1-4 or 5		Me. Do NOT us	e retired.)	not or working		. 25					
9	COMPL	2 Secretary U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)												
at on	E C									,				
fled	00	John Bobby Elizabeth Skapik 19a. INFORMANT'S NAME (Type/Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
be notified at once.	2	Francis J. Frattali 2700 Emmet Rd., Silver Spring, MD 20902												
must		1 M Burial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) Gate of Heaven Cemetery 5/13/95 Silver Spring, MD												
Iner		21. SIGNATURE OF FUNERAL SERVICE LAC	ENSEE A	1/1/		22. NAME	AND ADDRESS OF F	ACILITY						
the medical examiner must		1//ach 1	//ll	elh		500 U	is J. Co niversit	y Blv	d.W.	Sil.Sp	r.MD	Inc. 20901		
edica		23. PART I. Enter the diseases, or o shock, or heart feliure.	complications the	t coused the dise on each lin	death. Do n	not enter the m	ode of dying, su	ch aa can	diac or reap	iratory arrea	it,	Approxim		
E		IMMEDIATE CAUSE (Final disease or condition										Onset an		
m,		resulting in death)				Failur	e					Year	S	
54			OUE TO (OR AS A CONSEQUENCE OF): Chronic Bladder Infection											
or other traumatic event,	ERTIFICATION	equentially list conditions,											S	
trac	S	If any, leading to immediate cause. Enter UNDERLYING Renal Insufficiency 1-2 Yrs												
other	E	CAUSE (Disease or Injury that initiated events		(OR AS A CONS		•			-					
	ER	resulting in death) LAST	d. Alzh	eimer's	Dise	ase						Year	S	
shows any injury,	١٢	PART II. Other significent condition	a contributing to	deeth but not	resulting i	In the underlyle	ng ceuse given in	Part I.	24a. WAS AN	AUTOPSY	24b. WI	ERE AUTOPSY	FINDINGS	
any	EDICAL								PERFO		CC	MILABLE PRIOF		
DWS	MEC									24 110		F DEATH?	NO	
23 sh		DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	S NO [M UNCERTAI	N 🗆						
Item 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL/	ACE OF DEAT	TH (Check only one)							
or it	YSI	1 TYES 2 XNO	1 Inpetient 2	XER/Outpatient	3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Residence	8 🗆 Othe	r (Specify)					
	PHY	27. MANNER OF DEATH 1 X Natural 5 Pending	28s. DATE OF (Month, D	INJURY lay, Year)	28b. TIM	URY W	IJURY AT ORK?	28d. DE	SCRIBE HOW	INJURY OCCU	RED			
	BY	2 Accident Investigation	00- 01405.0	T IN Allend			YES 2 NO	-						
78	ETE	3 Suicide 8 Could not be 4 Homicide determined	building,	etc. (Specify)	nome, rarm, s	street, factory, offi	ice	281, LOC City	ATION (Street or Town, State,	and Number or)	Rural Rout	le Number,		
IMPORTANT: If Item	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE										nd manner as	stated.	
BITA	- 11	296. SIGNATURE AND TITLE OF CENTURES	11	7			29c. LICENSE NU	MBER		29d. DATE S	SIGNED (M	onth, Day, Year,		
IMPC	O BE	D43430 May 11, 1995												
	5	30. NAME AND ADDRESS OF PERSON WHO					#212 , 01:	nes7	MD 21	0832				
		31. DATE FILED (Month, Day, Year)	32. AEGISTRA	Ars SIGNATURE		Th Dr.	, UI	ircy,	اک سند	0032				
		MAY 12 1995	Julia do	audion Re	endall									



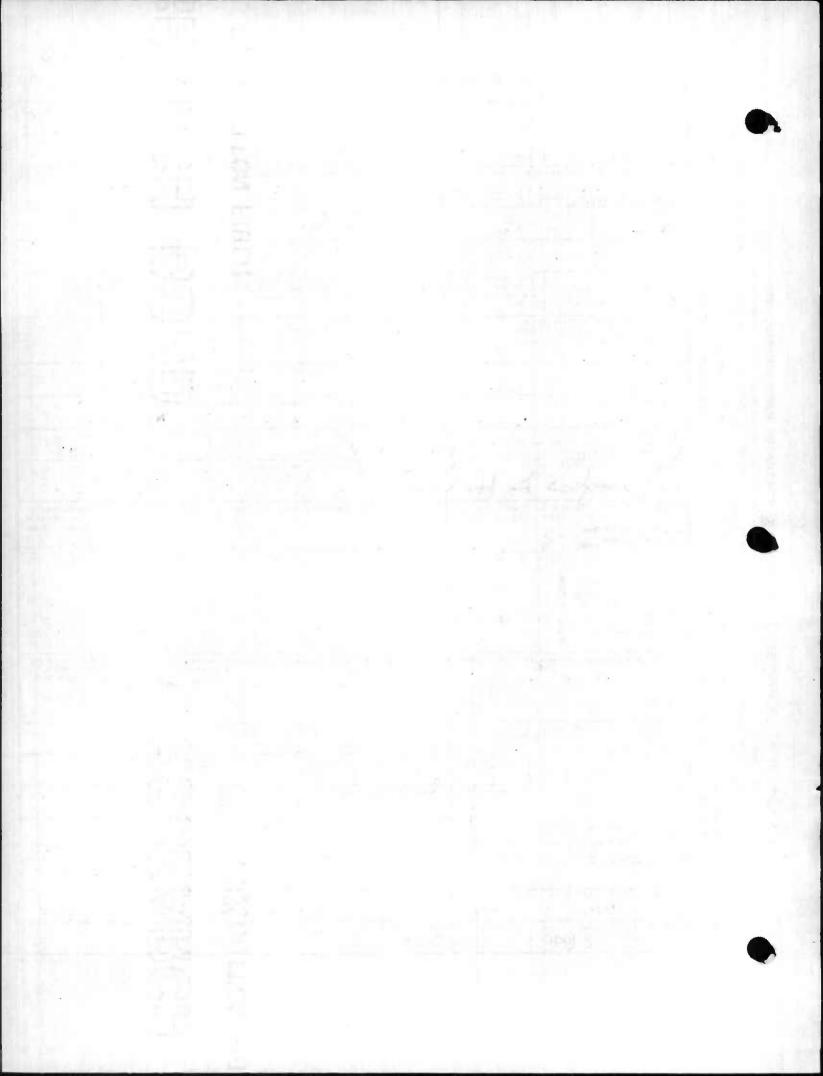
	1 - FOR STATE OF REGISTRAR	MARYLAND / D CEF	EPARTMEN RTIFICAT			MENTAL	HYGIENI REG. NO.	Ε		
	1. DECEDENT'S NAME (First, Middle, Leat) EMMA C FRIEN	10				2. DATE MONTH	OF DEATH DA	100	EAR .	3. TIME OF DEATH P
	4. SOCIAL SECURITY NUMBER 212-74-4185 9. FACILITY NAME (if not institution, give street end number)	6. AGE (In yrs. lest bi	YRS. MONTHS	DAYS H	IF UNDER 24 HRS.	MAY	Dep. Vent)	900	MAR	RYLAND
TOR	CUMBERLAND NURSING H	OME			RLAND	EATH		ALL		
DIRECTOR	MARYLAND 10b. COUNTY ALLEGANY		CRES	OR LOCATION						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER 14623 REDWOOD STREE	T		101. Z	21502	10	10	No. of the latest and	S A	HAT COUNTRY?
BY		NT EVER IN U.S. ARME 1 YES 2 NO WAR OR DATES		It yes, speci	DENT OF HISPAI fy Cuben, Mexica ND Specif	n, Puerto R		or No- 14		American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	+) (Give life. Do	DENT'S USUAL C kind of work done o NOT use retired.)	during most o	of working	16b.	OWN I		TRY	
8	17. FATHER'S NAME (First, Middle, Lest)			1	IS. MOTHER'S NA				D 0 W	
B	ELIJAH MORROW FRI 190. INFORMANT'S NAME (Type/Print)				EMMA				ROY	ER
2	HAROLD B. FRIEND, JR	. 13	100 S	ECOND	AVE.	CRE	SAPTO	WN,	MD	
	20e. METHOD OF DISPOSITION 120 Burial 2 Cremation 3 Removal from State Donetion 5 Other (Specify)		REST	BURIA	L PK	5/9		MBER		D, MD
	DOUGHOUSE OF FUMERAL SERVICE LICENSEE	tale	H	AFER		L OF				ORTUARY D 21502
	23. PART I. Enter the disesses, or complications the shock, or heart failure. List only one call IMMEDIATE CAUSE (Final disease or condition resulting in death) a	on any O		, ,		h aa card	fac or reapid	ratory arree	1,	Approximate interval Between Onset and Death
CERTIFICATION	rany, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	O (OR AS A CONSEQUE								
BY PHYSICIAN: MEDICAL C	PART II. Other significant conditions contributing to		uiting in the u	inderlying o	cause given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		OTHE		CE OF DEATH (CA	eck only on	0)		1	
YSI	1 YES 2 NO 1 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA 4 50, Nu	ursing Home	5 - Residenca					
зу Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	Day, Year)	28b. TIME OF INJURY M	28c. INJUR WORK 1 YES		28d. DES	CRIBE HOW II	IJURY OCCU	RED	
	3 Suicide 26e. PLACE	OF INJURY — At home g, etc. (Specify)	, term, street, fed	ctory, office		281. LOC. City	ATION (Street or Town, State)	nd Number or	Rurel Ro	oute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beet of MEDICAL EXAMINER: On the basis of									end manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CENTIFIED			2	PSc. LICENSE NU					Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA	USE OF DEATH (ITEM :	15 KEN	ITA	0332		PIANI			21502
	31. DATE FILED (Month, Day, Year) 32. REGISTE	IAR'S SIGNATURE		/ ///	JL, CQ,		2.77.2	-, , ,		2:302

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

DHMH-16 Rev 1/89



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR

MICHELLE D. GIFFORD 1. SOCIETY MARKER PLAN MAY 9, 1905 1746 PM 1. STATE OF PARTY 1. ST	_	REGISTRAN		U	=NIII	CALE	JE DEF	VI PI	REG. NO).		
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Olin I. Molesworth, P.A. 2010 Ridge Rd., Damascus, Md. 20872 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felture. List only one cause on each lina. Approximate interval between constituting in death Last Oue TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): d. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A CONSCOUENCE OF): A. DUE TO (OR AS A CONSCOUENCE OF): DUE TO (OR AS A			ENSEE	ua	00 01	22. NAM	E AND ADDR	2/72 ESS OF FAC	SILITY SI	Tver	Spri	ng, Ma.
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4 Nomicide determined Street Chy or fown, State) Brink Rel-Ret 27 29e. CERTIFIER (Check only one) 2 X MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Vear) MAY 11, 1995 30. NAME AND ADDRESS OF PERISON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201		2 Cutatta	28a. PLACE OF IN.	JURY — At hor	ne, farm, st	reet, tectory,	ffice		281. LOCATION (Street	and Number	r or Rural Ro	uts Number.
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Denote the Completed Cause of Death (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	- 10	296. SIGNATURE AND TITLE OF CERTIFIER	N.				29c. LIC	ENSE NUM	BER	29d. DAT	E SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Typo, Print) 111 Penn Street, Baltimore, Maryland 21201		Donnia 1	Christo	wD			0	.C.M	. E			
111 Penn Street, Baltimore, Maryland 21201	2	30. NAME AND ADDRESS OF PERISON WIN	COMPLETED CAUSE OF	F DEATH (ITEM	1 27) (Type /	Print)						
MAY 1 5 1995 32. DEGISTRAP'S SIGNATURE Sulva Division Roules		-		111 1	Penn		et, I	Balt	imore, M	aryl	and	21201
			32. DEGISTRAP'S !	SIGNATURE CLOSE	delli							

Si a g g a si ini

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

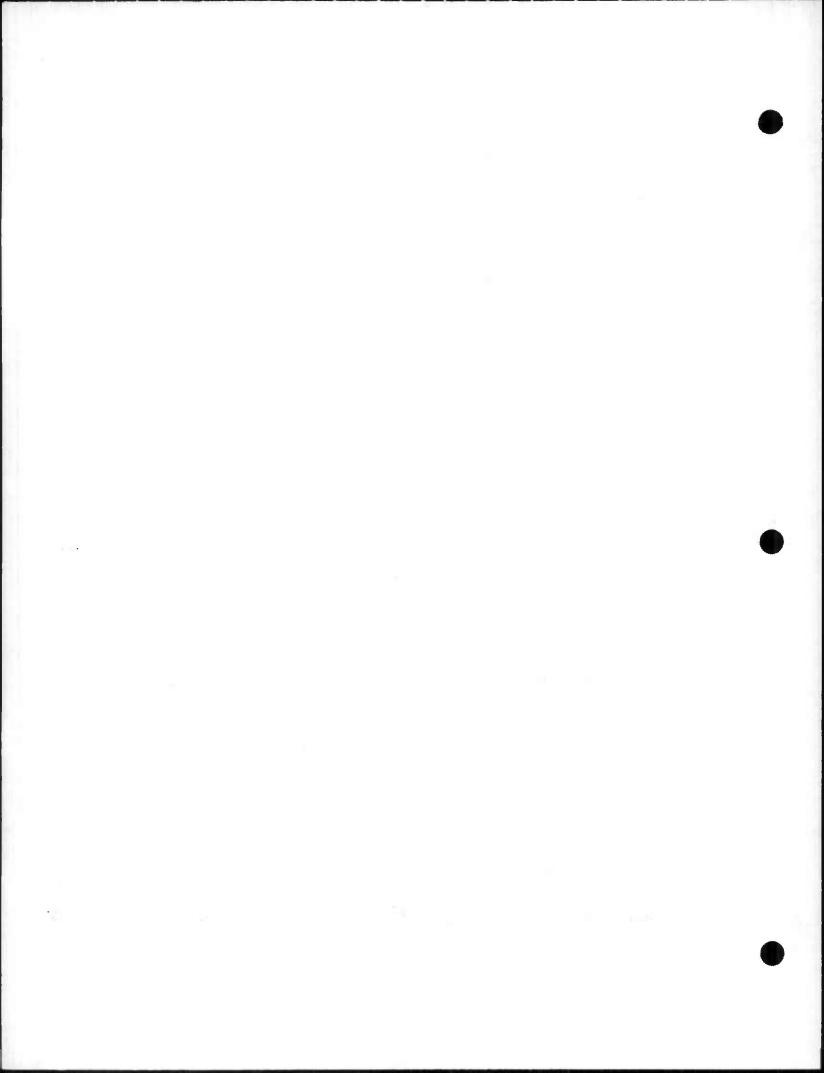
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

	REG. NO.												
	1. OECEDENT'S NAME (First, Middle, Las	1. OECEDENT'S NAME (First, Middle, Lest) Margaret Ethel Galloway 2. DATE OF DEATH MONTH OF DEATH MONTH OF 1995 4:00 P											
						May :							
	4. SOCIAL SECURITY NUMBER 215-32-0952	5. SEX 6. AG	E (In yrs. lest birth	MONTAGE	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day Year) Mar II,	190	e. BIRTHPLACE (State or Foreign Country) Maryland					
	9a. FACILITY NAME (If not institution, give	e street and number)		9b. CITY, T	OWN OR LOCATION OF	DEATH	0c. COUN	TY OF DEATH					
DIRECTOR	7631 Route	29 P.O Bo	x #141	. Sir	mpsonvill	e	How	ard					
<u>입</u>	10e. STATE 10b. COU	NTY	10c	CITY, TOWN OR	LOCATION			10d. INSIDE CITY					
	-	ard			sonville			LIMITS?					
FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?					
1 15	7631 Route #	29 P.O Box	#141		21150		U.	S.A.					
ا جُ	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED			ANIC ORIGIN? (Specify Ye	e or No-	14. RACE — American Indian, Black, White, etc.					
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			res, specify Cuban, Mexic YES 2 NO Speci			Specify: Black					
COMPLETED	15. DECEDENT'S En (Specify only highest gre	OUCATION ide completed)	(Give kind	NT'S USUAL OCC	UPATION ing most of working	16b, KIND OF BU	SINESS/INDU						
	Elementary/Secondary (0-12) 6th Grade	College (1-4 or 5+)		ot use retired.) ne-Make	~ r	None							
8	17. FATHER'S NAME (First, Middle, Last)		1101	ie-Make									
	Daniel Thomas Idella Allen												
9E													
임	Mrs Ruth V. J	ohnson	763	I Rout	e#29 P.O	Box 141	Simp	sonville, Md					
	20a. METHOD OF DISPOSITION 1 St Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Company of Control of Con												
1 1													
Ш	Snowden Funeral Home P.A. 20850 246 N. Washington St. Rockvill												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final													
	resulting in death) a. CEREGRO VASCULAR ACUSEM DUE TO (OR AS A CONSEQUENCE OF): 2 Hours												
NO	Sequentially list conditions,	b	HPERT A CONSEQUENCE	ENSION									
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS	A CONSEQUENC	E OF):									
FI	CAUSE (Disease or injury that initiated events	OUE TO (OR AS	A CONSEQUENC	E OF):	-								
H	resulting in death) LAST	d											
	PART II. Other algnificant conditi	ons contributing to death	but not resulti	ing in the unde	riving cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS					
EDICAL		+ EmEr 1				PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
MEC						1 _ YES 2	Nº MO	OF DEATH? 1 ☐ YES 2 ☐ NO					
	DID TOBACCO USE CON	TRIBUTE TO CAUSE	OF DEATH	YES NO	UNCERTA	N 🗆							
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	WOOD!TA	26. PLACE OF	DEATH (Check only	y one)								
Š	1 TYES 2 THO	HOSPITAL: 1 Inpetient 2 ER/Ou	rtpetient 3 🗆 DC	OTHER:	g Home 5 N Residence	6 Other (Specify)							
РНХ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)		TIME OF 26	Sc. INJURY AT WORK?	28d. DEŞCRIBE HOW I	NJURY OCC	JRED					
84	1 Netural 5 Pending 2 Accident Investigation				1 YES 2 NO								
<u>n</u>	3 Suicide 8 Could not b 4 Homicide datermined	e building, atc. (Sc	RY — At home, fai secify)	rm, street, factory	, offica	281. LOCATION (Street City or Town, State)	and Number o	r Rural Route Number,					
٦	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attated.												
COMPL								cause(s) end manner es stated.					
ш	29b. SIGNATURE AND TITLE OF CERTIF			-	29c. LICENSE NU			SIGNED (Month, Day, Year)					
B 0	En 1	La mo			10250	347	1 m	AY 9 1995					
유	30. HAME AND ADDRESS OF PERSON V	VHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)				1, 1, 113					
	31. DATE FILED (Month, Day, Year)	m 5	540 7	N OMY	ROD CV	ARKSVICHE	m	0 4019					
	31. DATE FILED (MONTH, Day, You) 32. BEQUETRAP'S SIGNATURE MAY 10 1995 Julia dawdson Raydall												

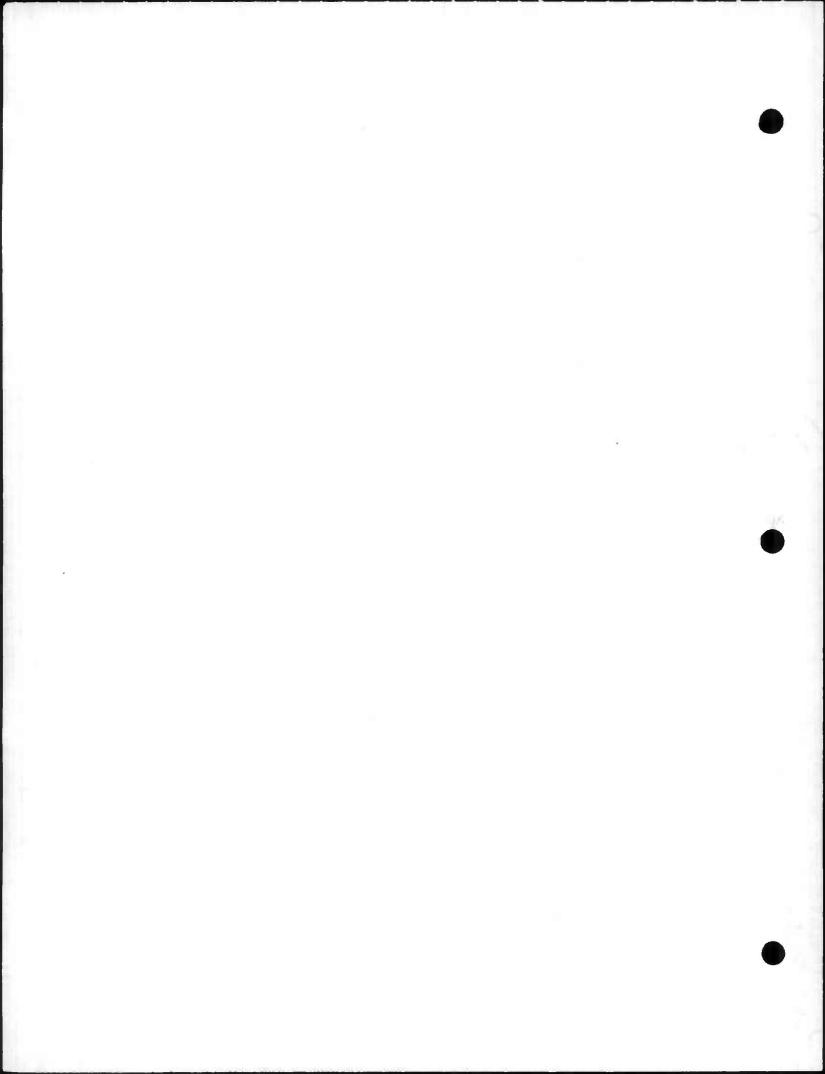


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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	the company of the contract of

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	3. TIME OF DEATH						
	Martha]	Lina R.	Good	rich	May 4.	1995 3:40 A						
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS	7. DATE OF BIRTH	1777						
	578-82-2922	1 □ M 2 💢 F	58 YRS.	MONTHS DAYS HOURS MIN	March 18.	Panama						
1	9e. FACILITY NAME (If not institution, give st	treet and number)		96. CITY, TOWN OR LOCATION OF		9c. COUNTY OF DEATH						
DIRECTOR	Washington Adventi	ist Hospital		Takoma Park		Montgomery						
	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,	10c CITY	TOWN OR LOCATION								
I E			.0.			16d. INSIDE CITY LIMITS?						
	Maryland Mont	gomery	Tal	koma Park		1 YES 2 NO						
18	7051 Carroll Aven	#607		20912-4								
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DECENDENT OF HIS		U.S.A. or No.— 14. RACE — American Indian.						
	1 Never Married 2 Married	FORCES? 1 YES		If yes, specify Cuben, Max 1 YES 2 NO Spe	ican, Puerto Rican, etc.)	Black, White, etc. Specify:						
84	3 Widowed 4 Divorced					Black						
TED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kind of we	ISUAL OCCUPATION ork done during most of working	16b. KIND OF BUS	INESS/INDUSTRY						
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use									
COMPLET	12		Housekee		Maintena							
	17. FATHER'S NAME (First, Middle, Last)				NAME (First, Middle, Maiden :	Surname)						
B B	Albert Green 19a. INFORMANT'S NAME (Type/Print)		F10071111111111111111111111111111111111	Rose								
2	Sondra Nelson			ADDRESS (Street and Number or Rui								
	20a. METHOD OF DISPOSITION	201		ETZETOT KOAD # 2 FDISPOSITION (Name of		Maryland 20783 ATION - City or Town, State						
	tion Burial 2 ☐ Cremation 3 ☐ Remo	oval from State Cen	etery, cremetory or oth		5/11/99							
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	orge wasi	22. NAME AND ADDRESS OF		phi, Maryland						
	1 = +1. 1	21 0- 1				al Home, Inc.						
	23 PART I Enter the diseases or	Y. Como	200	500 Universit	y Blvd.,W.	Sil.Spr.,MD 20901						
	23. PART I. Enter the diseases, or cahock, or heart failure.	List only one cause on a	ach lina.	ot enter the mode of dying, s	uch aa cerdiac or reapi	atory arrest, Approximata Interval Between						
	IMMEDIATE CAUSE (Final disease or condition	Ac. to	voc.	lantin atal	10.11.	Onset and Das						
	resulting in desth)	DUE TO (OR AS A	Xacev	10010107 Ch	rinic dos	NO(1) ve						
		Poplik	CONSEQUENCE OF	2.1.	Mic dos Pulmonari andoy E	di ease						
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	Willow SC	andoy 1	atoria						
¥	cause. Enter UNDERLYING	Gastvar	itrob.	has Rles	dring	sauce !						
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	PPCT	7							
F	resulting in death) LAST	d,										
	PART II. Other algnificent conditions	e contributing to death h	ut pot secultina la	About doubter and the								
I	HYDEV HA-C	s contributing to death b	at not resulting in	the undarrying couse given	In Part I. 34s. WAS AN A PERFORM	MED? MAILABLE PRIOR TO						
MEDIC	Porte Liver o	190	- A F	- chare 1	1 [] YES 2	ONFLETION OF CAUSE OF GEATH?						
Σ	DID TOBACCO USE CONTR	hame ox		DINO I UNCERTA		1 TYES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	Amend and an annual or	шПП							
SICI	EXAMINER?	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp	STATE STATE OF THE	OTHER:	723							
Ě	27. MANNER OF DEATH	28s. DATE OF INJURY	286. TIME	OF 28c. INJURY AT	28d. DESCRIBE HOW IN	HIRLY OCCURED						
	10 Metural 5 Pending Investigation	(Month, Day, Year)	INJU		110 3103 1100 1100	2011 3003160						
ЭВУ	2 Accident sinvestigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	- At home, farm, str	TOTAL CONTRACTOR STATE CONTRACTOR	28f. LOCATION (Street at	nd Number or Rural Route Number						
E	4 Homicide determined	building, etc. (Spec	*67		City or Town, State)	STATE OF THE STATE						
COMPLETED	29a. CERTIFIER TO CERTIFYING PHYSIC	CIAN: To the heat of my know	ladge death comme	st the time, data and place, and d								
ME						er as stated, idua to the cause(a) and manner as stated.						
	29b. SIGNATURE AND TITLE OF CERTIFIER											
8	THE OF SERVICE	Salver	711	29c, LICENSE N	1 Q 7	29d. DATE SIGNED (Month, Day, Year)						
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED VAUSE OF DE	ATH-(TEM 27) (Type 1	Print)	017/-	MAVE						
	HNEES HU	AN1 7610		OLLAVE, SUIT	£ 280 Tai	11061, 15						
	31. DATE FILED (Month, Day, Year)	32. RÉGISTRAR'S SIGN	ATURE	VLL , JUL , JUL /	- 301, 1AKO	MATARK MA						
	MAY 1 0 1995	3r. RÉGISTRAR'S SIGN	Kardall			20912						



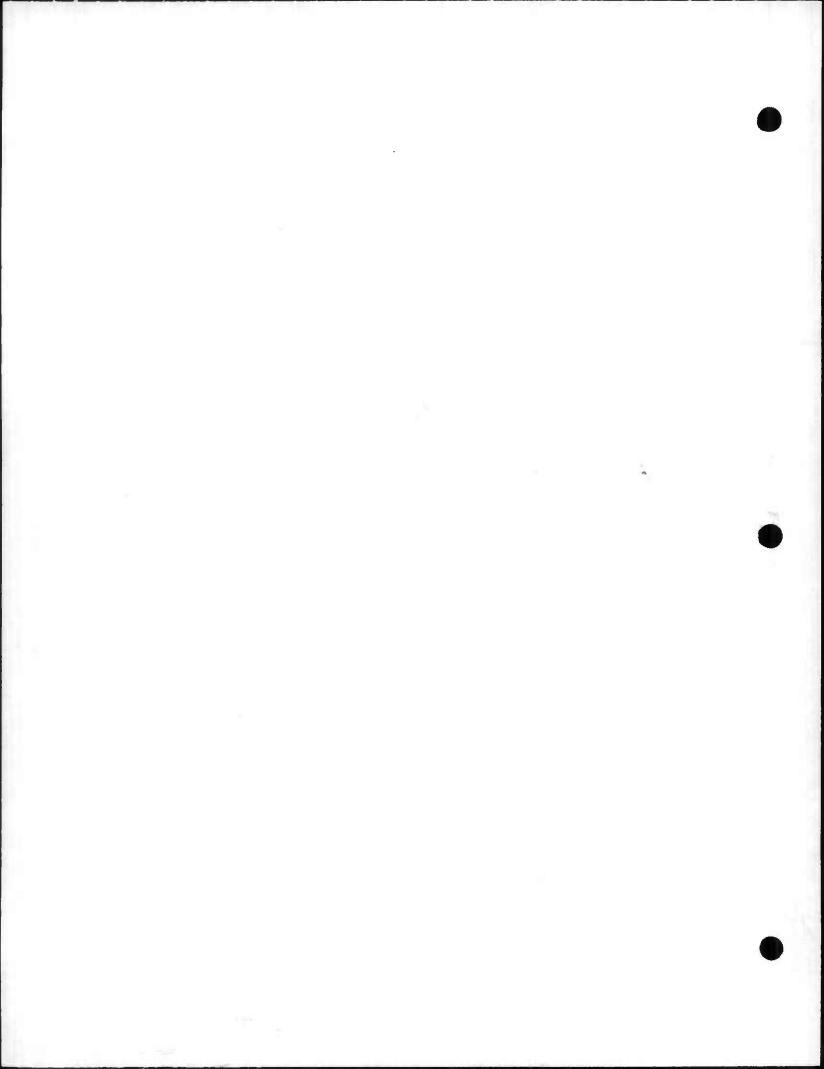
DIVISION OF VITAL RECORDS, P.O. BOX 68760, S BALTIMORE, MARYLAND 21215-0020

		1 - FOR STATE REGISTRAR		STATE OF M	MARYLAN				EALTH AND DEATH	MENT	AL HYGIEN REG. NO	E			
		1. DECEDENT'S NAME (First, A		ESSICA	J00 H	EE GUI	N			MON	TE OF DEATH DAY 3 19		EAR 3.	12:5	P
2		4. SOCIAL SECURITY NUMBE 423–23–4678	1 [SEX	6. AGE (In yr. 14	s. last birthday) YRS.	IF UNDER	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH nth, Day, Ybar) NUARY 1	.3,1981	Country)	OUL, S.	Foreign KOREA
2, 3 should	OR	90. FACILITY NAME (# not inst NATIONAL 1	NAVAL MI		CENTE	96. CITY, TOWN OR LOCATION OF DEATH R BETHESDA						9c. COUNTY OF DEATH MONTGOMERY			
permit. Pages 1,	DIRECTOR	3.00	PRINCE	WTLLTAM	1		E CIT		TION					d. INSIDE C	
	FUNERAL (100. STREET AND NUMBER 5831 RIVERSI				12/11	<u> </u>	101	2193			10g. CITIZE	N OF WHA		
Z4 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit ion, or removal. The medical examiner must be notified at once.	В	11. MARITAL STATUS 1 Never Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 1 Nover Married 1 Nover Married Ma	12.	WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	□ NO	lf lf	AS DEC	ENDENT OF HISPAI polity Cuban, Mexica 2 NO Specif	n, Puarte		or No.— 14	BACE -	Americen in	ndlen,
ospital or attend thed for use as	COMPLETED		DENT'S EDUCATION Alighest grade com Com Com Com Com Com Com Com			Give kind of life. Do NOT L	work done di ise retired.)	CUPATIO	ON st of working	16	SCHOOL		TRY		
ed by the hospit id be detached id at once.	BE COA	17. FATHER'S NAME (First, Mick PHILLIP C.	GUIN						18. MOTHER'S NA SANDR			Surname)			
ay be retained page 5 should be notified	2	PHILLIP C.	GUIN			5831	RIVER	SID	E DRIVE,	DAI	E CITY	, VIRO	INIA		3
director, p		20e. METHOD OF DISPOSITIO 1	3 Removal		20b. PL/ cemelery METR(CE AND DATE V, Crematory or COPOLIT	AN CR	EMA'	TORY	5/4	1/95 _{ALE}	CATION — CH			ITA
ter death. Page 6 m the funeral director, waf.		Tordo	a Se	Ma	ue	٤	45	10 T	Y FUNERA WILSON B	L HO	ME, IN	C. A. 222	203		
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		22 PART I. Enter the dis- ahock, pr her IMMEDIATE CAUSE (Fine disease pr condition resulting in death)	ert tellure. List	ASPIR	ATION	PNEUM	ONIA	he mo	de of dylng, suc	h ss ce	rdisc or respi	ratory srree	t,	Onset s	Between and Desth
th certificate be executed ending physician and con I Hygiene prior to burial, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										14	years		
that the dea ned by the att th and Menta any injury,	AL	PART il. Other significent	conditione co	entributing to	deeth but n	ot resulting	in the und	erlying	csuse given in	Part I.	24s. WAS AN PERFOR	IMED?	AM	RE AUTOPSY VILABLE PRIC MPLETION O	OR TO
v requires been signe t, of Health	4: MEDIC	DID TOBACCO US	E CONTRIB	ITE TO CAL	USE OF D	DEATH Y	FS \square N	0 🗆	UNCERTAI		1 TYES 2	(X NO		DEATH?	□ NO
N: The law ficate has I State Dept item 23	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 X NO	MEDICAL	OSPITAL:	26. 1	PLACE OF DEA	OTHER	ily one)							
OR ATTENDING PHYSICIAN: The law requires that the DIRECTOR: After this certificate has been signed by hours after death with the State Dept. of Health and Item 28 is marked, or item 23 shows any is	ву РНУ	27. MANNER OF DEATH 1 X Natural 5 Pe		28a. DATE OF (Month, Da	INJURY	28b. TIR		8c. INJU			ESCRIBE HOW I	NJURY OCCUP	RED		
ATTENDING ECTOR: After s after dea 1 28 is m	6	3 Suicide 8 Co	ould not be starmined	28e. PLACE Of building, o	FINJURY — A etc. (Specify)	At home, ferm,	street, fecto	y, office			CATION (Street e y or Town, State)	and Number or	Rural Route	Number,	
HOSPITAL OR ATTENDING FUNERAL DIRECTOR: After within 72 hours after death TANT: If Item 28 is ma	COMPLET	one) 2 MEDIC	AL EXAMINER: O						and place, end due				euse(s) sn	d menner es	stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	TO BE	296. SIGNATURE AND TITLE O	Parol	eth	mo				29c. LICENSE NUI		(VA)	29d. DATE S	1919	onth, Day, Yea	ir)
		30. NAME AND ADDRESS OF F W. PADGE 31. DATE FILED (Month, Day, Ye	TT. LT.	MC. IIS	SN		e, Print)		NATIONAL BETHESDA				CENT	ER	
		MAY 0	3 1995	32. DEGISTRAI	wolor/	Carolalle									-18 Rev 1/89

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filed within 72 hours after death with the State Debt, of Health and Mental Hotelete prior to burial, cremaration, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Amended ± 196 FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEACH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH													
	Virginia A	nn Gli	smann							May 5,	100		YEAR	12:34 A M
	4. SOCIAL SECURITY NUMBER	DER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BI	RTH		S. BIRTH	PLACE (State or Foreign
	528-40-3463		1 M 2 F	61	YRS.	MONTHS	DAYS	HOURE	MIN.	(Month, Duy, March		934	Uta	
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)										NTY OF D	
O.	Montgomery	Gener	al Hospi	tal			01	nev				Mon	ntgomery	
딦	RESIDENCE OF DEC	10b. COUNT			100 017	Y, TOWN (11011		
DIRECTOR	Maryland		tgomery					ION						10d, INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	PIOII	rgomery			Olne		. ZIP CODI				10- 017	75N OF V	1 YES 2 NO
FUNERAL	19428 Olney	Mil1	Road				1	208			- 1	log. Cit		
3	11. MARITAL STATUS	11111	12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13.	WAS DEC			HC ORIGIN? (Spe	cify Yes	or No-		S.A.
ВУ Е	1 Never Married 2 📉			YES 2XN	10		f yes, sp	2 K NO	n, Mexica	n, Puerto Rican,	etc.)		Biack Speci	— American Indian, L, White, etc.
	3 Widowed 4 Divo								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					nite
COMPLETED	15. DEC (Specify only	EDENT'S EDU y highest grade	CATION completed)	(GI	CEDENT'S	vork done	CCUPATIO	ON at of working	g	16b. KIND	OF BUS	INESS/IN	DUSTRY	
7	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Do NOT us									
N N	17. FATHER'S NAME (First, M	Virialia (not)	4		omem	aker					1 Ho			
EC	DeLoss Wil									ME (First, Middle,		Sumame)		
0														
2												0000		
Í	20s. METHOD OF DISPOSITION 1 © Burlai 2 Cremation 3 Removal from State 20b. PLACE ADDATEO PISPOSITION (Name of camelany gramatory or other class). 20b. PLACE ADDATEO PISPOSITION (Name of camelany gramatory or other class).													
	4 □ Donation 6 □ Other		oval from State	- Norbec	hetory or of	nori	a1 P	ark	5	/10/95				
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	n		22.	NAME AN	ID ADDRES	SS OF FA	CILITY				
	- (Ima	1011)	(/(2	Vo		50	ancı O Un	S J.	COL	lins Fu	iner	al H	ome,	Inc.
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate												Approximata	
shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) s. AWTE NEGROW WAY MYO CARGO NEGROW NE												Interval Between Onset and Death		
	disease or condition resulting in death)	→	. AWTE	NEFP	0	WAL	_ 1	Myn	CAAa	in la	IFA) (7)	. 1	3 Hours
i	rosuning in oesan)			(OR AS A CONSEC	UENCE OF):		10.	C IV	140		- 410	7	31000
Z	Sequentially list conditi	one C	h											
CERTIFICATION	if any, leading to immediates. Enter UNDERLYI	diete	DUE TO	(OR AS A CONSEC	UENCE OF):								
E I	CAUSE (Disease or Inju		DUE TO	(OR AS A CONSEC	LIENCE OF	١٠								
E	resulting in deeth) LAS	т		(OIL NO IN CONSEC	OCIVOE OF	,.								
			J											
MEDICAL	PART II. Other algnifice	nt condition	a contributing to						iven in	Part I. 24a.	MAS AN	AUTOPSY MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	DIABETES	1 1	PECIEN	5102	HY DE	30_CI	PIDE	ALM		_ 10	YES 2	NO.		COMPLETION OF CAUSE OF DEATH?
~ 1	DID TODA 600 11													1 TYES 2 NO
AN	DID TOBACCO U		KIBUIE TO CA					UNC	ERTAIN	1 🔯				
PHYSICIAN:	EXAMINER?	MEDICAL	HOSPITAL:		E OF DEAT	OTHER	1:							
¥	27. MANNER OF DEATH		1 X Inpatient 2 =		28b, TIME	_	ing Home		sidence	8 Other (Spec		I II I III OO	OUDEO.	
		Pending	(Month, D		INJ		WO	RK7	NO.	24d. DESCRIBE	now in	IJUNY OCI	JUNED	
D BY	3 Suleide	nvestigation Could not be	28a. PLACE O	F INJURY — At hor	ne, farm, si	treet, facto			-	28f. LOCATION	(Street a	nd Number	or Rural B	oute Number
W		datermined	building,	atc. (Specify)						City or Town	, State)		O. Flarai I.	oute Workson,
COMPLET	29a. CERTIFIER 1 CERT	IFYINO PHYSIC	CIAN: To the best of	my knowledge des	th accurre	of mt the at	ma data	and alace	(24)					
N N	298. CERTIFIER (Check only one) 1 CERTIFINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
	296 SIGNATURE AND TITLE							29c. LICE			T			
H	Daniel Jema	AND A	k -	Val			ŀ	-	2110	BER		► M		(Month, Day, Year)
임	30. NAME AND ADDRESS OF	and Bol		ردام				- 14				1010	C pm	כדריו
	-	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type.	Print)							-	
	DANIEL LEO	MARID	GRAFFEL				Y 68	POVE	RD	POCKNI	ue	wid	ari	141
	DANIEL LEO 31. DATE FILED (Month, Day,	MARD (bar)	GRAFFEL 32. BEGISTRA	M 15	225		Y 68	POVE	120	POCKVI	ue	, MA	My C	DW
	DANIEL LEO	MARD	GRAFFEL 32. BEGISTRA	1 15	225		Y 68	POVE	RO	POCKVI	ue	ma	My C	IND



DIVISION OF VITAL RECORDS, P.O. BOX 68760

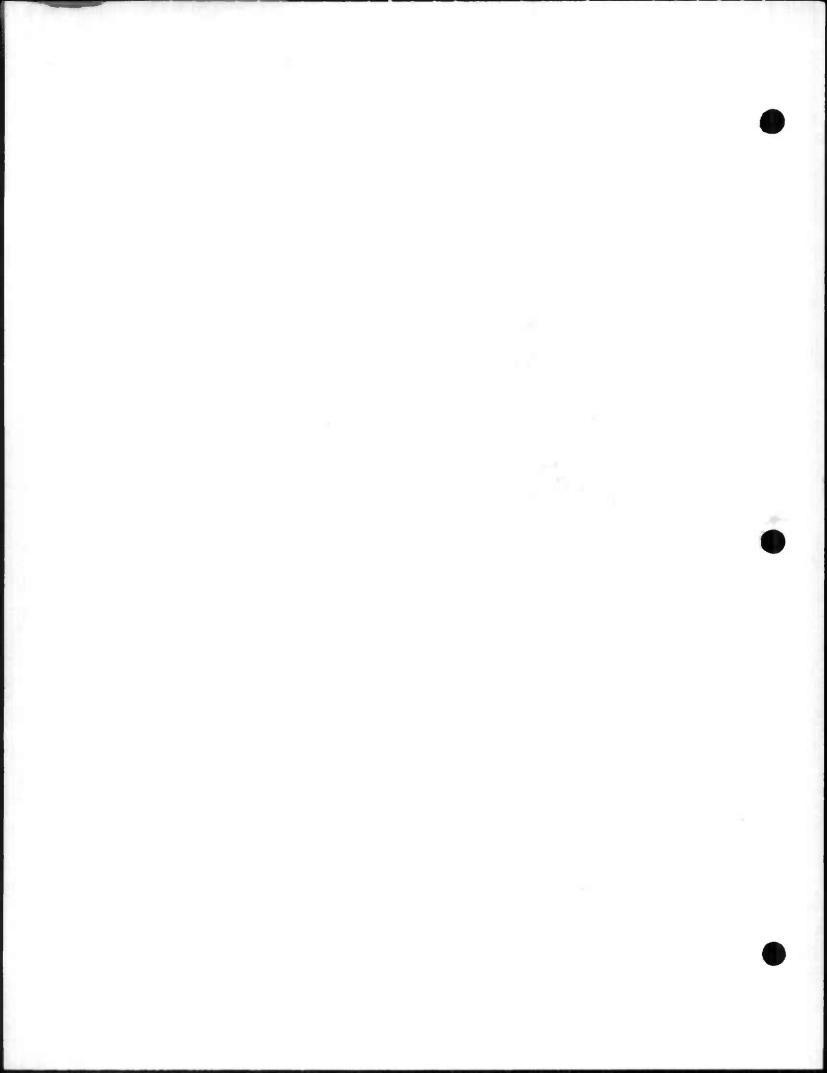
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit.

1 - FOR STATE REGISTRAR

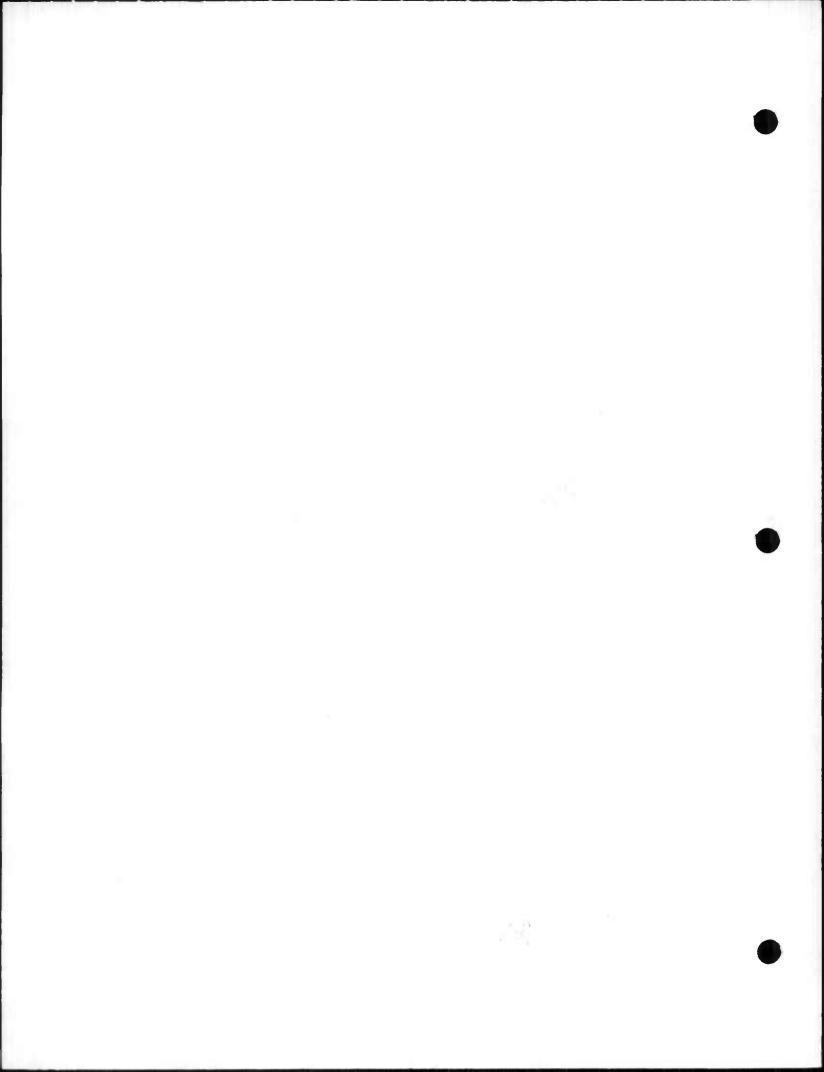
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1, DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH													
		Myron G	illesp	oie								May 9, 1	995	YEAR	3 A. M
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (in yrs. last	birthday)		R 1 YEAR		DER 24 HRS.	7. DATE OF BIRTH			PLACE (State or Foreign
		100-01-7120		7 M 2 F		95	YRS.	MONTHS	DAYS	HOURI	MIN.	Jan 18,	1900	conne	ecticut
2		9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CIT	Y, TOWN	OR LOCA	TION OF DE	EATH	9c. CO	JNTY OF D	EATH
2	OR	Shady Grove	Nursi	ng Cente	r			Ro	ockv	rille	5		Mon	tgome	ery
	5	RESIDENCE OF DEC	10b. COUNTY												
200	DIRECTOR							Y, TOWN		ATION					10d. INSIDE CITY LIMITS?
		MD 100, STREET AND NUMBER	Mont	gomery			De	erwoo		of, ZIP CO					1 X YES 2 NO
	FUNERAL		O1-	Desires					- ["						VHAT COUNTRY?
2	N.	17621 Mill	Сгеек	Drive 12. WAS DECEDEN	IT EVED II	1110 404	MED.	1.00	WW 0 0 0	2085				SA	2.00.000.00
8		1 Never Married 2	Married	FORCES? 1	YES	2 N	O		If yes, s	pocity Cu	ban, Mexica	HC ORIGIN? (Specify ' n, Puerto Rican, etc.)	es or No —	Biaci	— American Indian, c, White, etc.
2	BY	3 Widowed 4 Divo	becau	IF YES, OIVE V	WAH DH DA	(IES	1 ☐ YES 2 ☐ NO Specify:					<i>r</i> :		Spec	white
3	0		EDENT'S EDU				DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b, KIND OF E	USINESS/IN	DUSTRY	
5	COMPLET	Elementary/Secondary (I		College (1-4 or 5	+)	Itta.	Do NOT u	se retired.)	during in	NOSE OF WOR	NIII Y				
	M I	12				Ins	urar	ance Broker Insurance							
once.	8	17. FATHER'S NAME (First, M					16. MOTHER'S NAME (First, Middle, Maiden Surname)								
dat	BE	Harry Gille									-	Panikoff			
notified	2	196. INFORMANT'S NAME (•								Route Number, City or 1			
pe n		Frederick G		1e							Drive				
must		20a. METNOD OF DISPOSITION 1 Substitute 2 Commetter Comments 1 Substitute 2 Commetter										wn, State			
E		4 Donestion 5 Other (Specify) Judean Memorial Gardens 5-11 Olney MD 21. NOMATURE OF FUHERAL SERVICE USERNIEE CONTROL OF FUHERAL SERVICE USERNIEE CONTROL OF FUHERAL SERVICE USERNIEE CONTROL OF FUHERAL SERVICE USERNIEE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERVICE USERNIE CONTROL OF FUHERAL SERVICE USERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERNIE CONTROL OF FUHERAL SERVICE USERVICE USER SERVICE USER SERVICE USER SERVICE USER SERVICE USER S													
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or removal medical		23. PART i. Enter the d	iseases, or o	complications the	t ceused	the dea	ath. Do	not ente	r the m	ode of o	dying, suci	h as cardlec or rea	piratory a	rrest,	Approximate interval Between
		IMMEDIATE CAUSE (Fil		List only one set	230 011 01	-C17 11116.									Onset and Death
Health and Mental Hygiene prior to bunal, cremation, ws any Injury, or other traumatic event, the		disease or condition resulting in death)	→	. D	emen	tia									months
il, crema event,				DUE TO	(OR AS A	CONSEC	UENCE O	F):							
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rior to buri	RTIFICATION	if any, leading to imme cause. Enter UNDERLY		DOE 10	(DR AS A	COMSEC	DENCE O	₩ }:							
giene pr other t	윤	CAUSE (Disease or injury													
or ot	E	that initiated events resulting in death) LAST													
ental	CE			u,											
nd Menta	MEDICAL	PART ii. Other significe	ent condition	s contributing to	deeth b	ut not n	esulting	In the u	nderlyii	ng ceus	e given in		IN AUTOPSY DRMED?	24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
afth an	8	Rena	l Insu	fficienc	у							1 YES	2 X NO		COMPLETION OF CAUSE OF DEATH?
of Heal	Σ		_												1 - YES 25 NO
23 s	ä	DID TOBACCO U		RIBUTE TO CA				_			ICERTAIN	10			
State Dept. Item 23	PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:		17		TH (Check		9)					
2 6	XS	1 TYES 2 X NO		1 Inpatient 2	_	atient 3		430 Nu	rsing Ho		Rasidence	6 Other (Specify)			
marked,			Pending	28a. DATE OF (Month, E			26b. TIN	JURY	W	ORK7	_ wo	28d, DESCRIBE NO	INJURY O	CCUREO	
death with	BY	2 Accident	Investigation	28e. PLACE C	DE INJURY	_ A1 bor	ne lerm	etreet for		YES 2	□ NO	201 1 OCATION (Com	d mad Mumb	as as Osmal I	Secretar Abrambas
after d		3 Sulcide 8 4 Homicide	Could not be determined	building,	etc. (Spec	elfy)	110, 101111,	acroot, rec	nory, orn	100		281. LOCATION (Stree City or Town, Sta	(a)	or or moral r	vous Number,
hours		29e. CERTIFIER	versión esta du	. (1) 2 (20) (20)	io anti-										
127	MPL	(Check only										to the cause(a) and n			
ANT	8				- CONTROL OF THE	T STEED OF T	rveatigati	on, m my	opinion,				_) and manner as stated.
filed within 72 I	BE	296. SIGNATURE AND TITLE	OF CERTIFIE	A0 N							OCENSE NUM				(Month, Day, Year)
28 2	2	30. NAME AND ADDRESS O	E DEDSON WA	TI TY	SE OF DE	ATM /ITF	1 27) (5:-	Delett		I D	36552		1	May 9	, 1995
		P. Talwar							-1		- 10	20052			
3 1			JO W	Edmonsto	AR'S SIGN	TVE	#40	T K	OCK	VIII	e MD	20852			
_		31. DATE FILED (Maryl) Coy.	12 199	32. PEGISTRA	Much	orka	dall								
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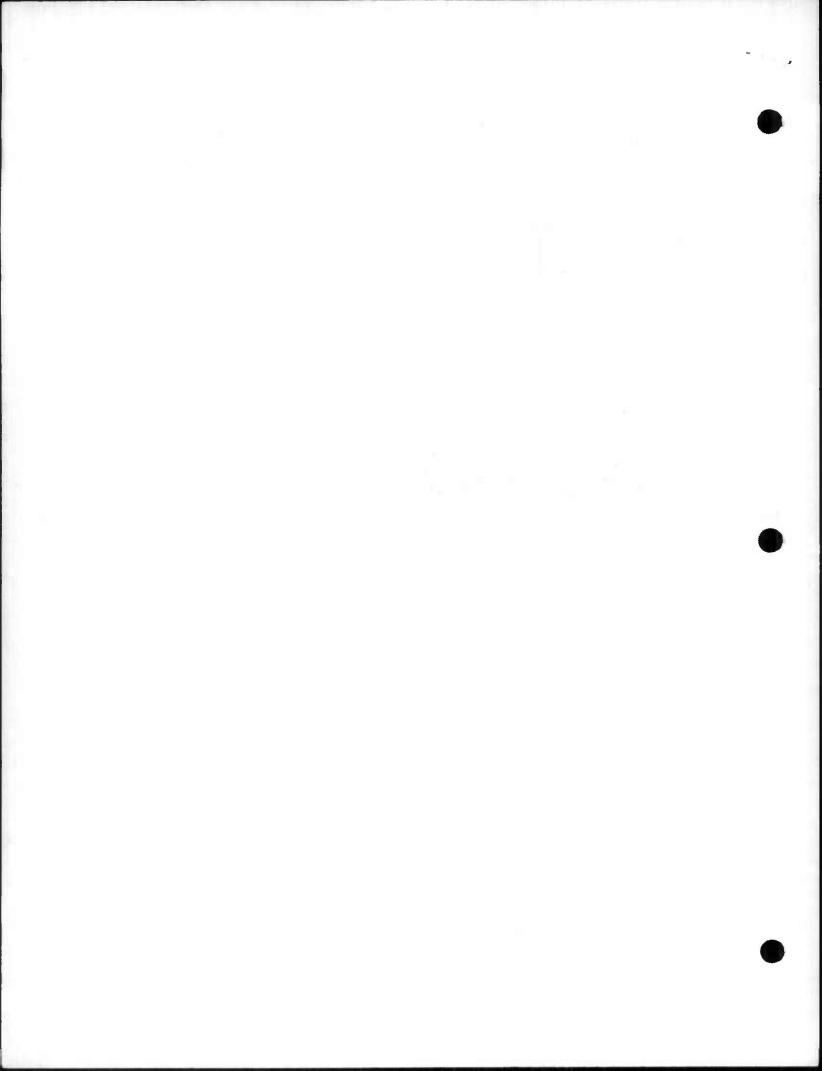
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the continued by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE HOSP	TO THE FUNE be filed within	MPORTANT

	1 - FOR STATE REGISTRAR	STATE OF MARYL				EALTH AND DEATH	MEI	NTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DEATN			3. TIME OF DEATN		
	IDA	Mae	GREI	EN				May 6, 19	95	YEAR	1:30 A M		
	4. SOCIAL SECURITY NUMBER 216-05-5743		In yrs. lest birthday)	IF UNDER		IF UNDER 24 HRS.	7.	DATE OF BIRTH (Month, Day, Year)		8. BIRTN Countr	IPLACE (State or Foreign		
		·	85 _{YRS.}	MONTHS	DAYS	HOURS MIN.		t.30,19	09	Md	"		
~	9a. FACILITY NAME (If not institution, give at Memorial Hospi	treet and number)				R LOCATION OF	DEATH		9c. COUNT				
0	RESIDENCE OF DECEDENT	Cumberland								Allegany			
<u> </u>	10a. STATE 10b. COUNTY		10c. Cl	ry, TOWN O	R LOCAT	ION					10d, INSIDE CITY		
DIRECTOR	Md Alleg	any	Lo	naco	nin	g					LIMITS? 1 YES 2 V NO		
	10e. STREET AND NUMBER				101	ZIP CODE			10g. CITIZI	EN OF V	VHAT COUNTRY?		
FUNERAL	General Del	ivery		21539									
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES		13.	MAS DEC	ENDENT OF NISP	ANIC O	RIGIN? (Specify Yes	or No-	4. RACE	— American Indian,		
ВУ	1 Never Married 2 Merried 3 Merried 4 Divorced	IF YES, GIVE WAR OR DA				city Cuban, Maxi 2 X NO Spe		Herto Hican, atc.)			hite		
	15. DECEDENT'S EDUC	16a, DECEDENT'S		201101111						litte			
Ë l	(Specify only highest grade Elementary/Secondary (0-12)	(Give kind of	work done r	during mos	nt of working		166. KIND OF BUS		STRY				
ᆲ	G Comments y/Secondary (0-12)	Home		r			110111						
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					16. MOTHER'S I	IAME (First, Middle, Melden	Surname)				
ш	William F. C	utter				Ida		Green					
10 B	Albert A. Gree	n	196. MAILIN	ADDRESS	(Street a	nd Number or Run	/ Playte	Number, City or Tour	State, Zig S	(Apr) 2	1		
-			DOX A		Vai	,	De		u . Z .	102	Т		
	20g. METHOD OF DISPOSITION 125 Buriel 2 Cremetion 3 Remo	20b.	PLACE AND DATE	OF DISPOS	ITION (Na				CATION — CI	-			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		etery, cremetory or certain Cer					3,1995	Lonac	con	ing,Md.		
		V		22.	Eich	horn-	McH	Kenzie :	Fune	ra1	Home		
_	Jana Mel	e		L	onac	coning	, Mc	1. 2153	9				
	23. PARY I. Enter the diseases, or conshock, or heart fellure. I	omplications that caused List only one cause on a	the death. Do	not enter	the mod	de of dying, su	ch as	cardiac or reepis	ratory arre	st,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final										Onset and Death		
	disease or condition resulting in death)	CVA									6 days		
		DUE TO (OR AS A		F):									
	Sequentially list conditions,	Hypertensic		fi:							Unknown		
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING			,							T		
Ĕ	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE O	F):					-				
	resulting in death) LAST	i									W		
AL C	PART II. Other eignificent conditions	s contributing to death be	ut not resulting	in the un	deriving	ceuse given i	n Part	1. 24e. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS		
<u>8</u>	Osteoarthritis				,			PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE		
EDIC								1 U YES 24	NO NO		OF DEATH? 1 YES 2 NO		
-	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH Y	S 🗆 N	10 K	UNCERTA	IN [ı			T TES 2 NO		
<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEA										
Š	1 VES 23 NO	HOSPITAL:	Itlent 3 DOA	OTHER		5 🗆 Residence	6 🗆	Other (Specify)					
PHYSICIAN: M	27. MANNER OF OEATN	26e. DATE OF INJURY (Month, Day, Year)	26b. TIR	IE OF JURY	28c. INJU	FRY AT	28d	. OEŞCRIBE HOW IN	JURY OCCU	RED			
2	1 Natural 5 Pending 2 Accident Investigation			М	1 🗌 Y	E\$ 2 NO							
- 0	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm,	street, facto	ory, office		28t.	LOCATION (Street at City or Town, State)	nd Number o	r Rural R	oute Number,		
COMPLETED													
<u> </u>	(Check only	CIAN: To the best of my knowle											
5		R: On the basis of examination	and/or investigation	on, in my o	pinion, de	ath occured at th	e time,	data and place, and	dua to the	cause(s	and manner as stated,		
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE											(Month, Day, Year)		
2	30. NAME AND ACCRESS OF PERSON WHO		TH ATEN AT C	Onlant'	\perp	D 463	46		May /2 1995				
					1.	C1	.1	1 100	01500				
	Dr. H. Shakil, Jo	I AESISTAAR'S SIGNA	s medic	al RI	.ag.	, cumbe:	ria	na, MD	21502	-			
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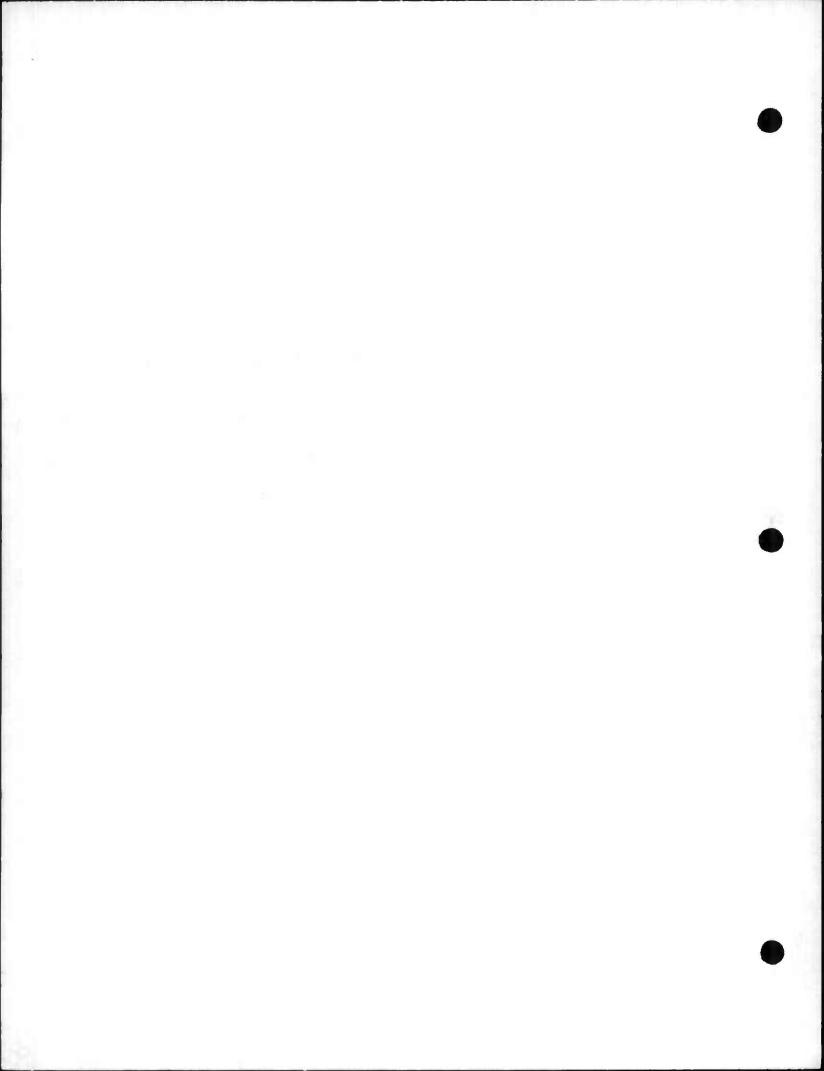
		FOR STATE REGISTRAR	STATE OF MARYL				HEALTH AND	MENTA	L HYGIEN	_			
		1. DECEDENT'S NAME (First, Middle, Last)	Elgin H	off	mar			2. DATE MONTO			3. TIME OF DEATH		
	1	4. SOCIAL SECURITY NUMBER 577-46-9011	5. SEX 8. AGE (1	in yrs. lest b 7		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Monti	OF BIRTH n, Day, Year)		BIRTHPLACE (State or Foreign Country) Maryland		
a c	5	On. FACILITY NAME (If not institution, give st Carroll County		ospi			or Location of D	EATH	,	9c. COUNTY	of DEATH		
1 5		RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY				OWN OR LOCA	TION						
DIRECTOR	- 10	9	rroll			Manch	ester				10d, INSIDE CITY LIMITS? 1 YES 2 X NO		
FUNERAL		2609 Bert Fowl	er Road			10	21102			10g. CITIZEI	USA		
3 ☑ Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 ☒ NO Specify:										. RACE — American Indian, Black, White, atc. Specify: White			
15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY											TRY		
COMPLET		Elementary/Secondary (0-12)	College (1-4 or 5+)		Sales			J	ellif	ff's I	Dept Store		
ed at one		Harvey Price					Jane E	liza	beth	Perry			
198. INFORMANT'S NAME (Type/Print) Daniel Hoffman 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Harney Road, Littlestown, PA 1734											A 17340		
must b		20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remark 4 Donation 6 Other (Specify)	avel from State 20b.	otoni orome	stone or other e	SPOSITION (N		5 / 15			or Town, State		
examiner		21. SIGNATURE OF GUNERAL SERVICE LIC	W. Ell	ne)	22. NAME A	ND ADDRESS OF FA	CILITY E	line	Funer	ral Home d, MD 21074		
or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Rtgut lower lobe previous product. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury course). Cougeshile heart failure.											
		CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUI	ENCE OF):	rane					1 33,		
rs any inju		PART II. Other eignificent condition		ut not rea	uiting in th	na underlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
S show		DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	F DEATH	H YES [J ON E	UNCERTAIL	N D			1 TES 2 NO		
ed, or item 23 s PHYSICIAN:		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ОТ	heck only one)							
d, or		27. MANNER OF DEATH	1 ☑ Inpatient 2 ☐ ER/Outpa 28e. DATE OF INJURY	7	26b. TIME OF	26c. IN.	JURY AT		(Specify)	NJURY OCCUR	RED		
marke BY P	- 10	1 Natural 6 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY		YES 2 NO						
3 Suicide 8 Could not be datermined 28s. PLACE OF INJURY — At home, tarm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, tarm, street, factory, office City or Town, State)										Rural Route Number,			
IMPORTANT: If item O BE COMPLE			CIAN: To the best of my knowle R: On the basis of examination								Buse(a) and manner as stated,		
PORTA BE C		296. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUM	MBER		29d. DATE SI	IGNED (Month, Day, Year)		
T B OT	131	M. NOWN	MD				D357	11		> 51	12 195		
		30. NAME AND ADDRESS OF PERSON WHO	cy General	Hosp) Memori	ial	Ave,	Westm	inster21157		
		MAY 15 1995 July	BE. REDISTRANT SIGNA	UPRE .				-					



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	fall OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Thouse after de
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		1 - FOR STATE REGISTRAR	STATE OF MARY		PARTMENT OF		MENTAL	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	F DEATH DAY		EAR 3. T	IME OF DEATH
		GEORGE	L.			COCK	МАУ		95		:35A M
P		4. SOCIAL SECURITY NUMBER 228-26-2945 9e. FACILITY NAME (If not institution, give	1 🖾 M 2 🗆 F	(In yrs. last birtho	S. MONTHS DAYS	HOURS MM.	Jan.	BIRTH Day, Year) 20, 1	927	Virg	E (State or Foreign
, 2, 3 should	стов	SUBURBAN HOSP:				HESDA	DEATH		MONT	GOME	RY
020 physician. burial-transit permit. Pages 1, 2,	DIRE	Maryland Mo	ntgomery	10c.	Kensingt					1	INSIDE CITY LIMITS? YES 2 [X] NO
E .	FUNERAL	10e. STREET AND NUMBER	-			IOI. ZIP CODE			10g. CITIZEI	N OF WHAT	COUNTRY?
an. ransit	Ü	10618 Parkwood				20895			Unit	ed St	ates
215-0020 attending physician. ise as the burial-tran	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 1 VES IF YES, GIVE WAR OR E	2 NO	If yes,	ecenoent of HISP/ epecify Cuben, Mexic ES 2 KNO Spec	an, Puerto Ric	(Specify Yes o an, etc.)	or No — 14	Black, Whi Specify:	merican Indian, ia, atc. hite
215 attenuse as	ETED	15. DECEDENT'S EDU (Specify only highest grad	ICATION	16a. DECEDEN	IT'S USUAL OCCUPAT of work done during it	TION	16b. K	IND OF BUSI	NESS/INDUS		nice
D 21 spital or	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	Equipment		r	Con	struc	tion	
AN the hor detact	8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N		ldle, Malden Si	urname)		
RYL, ed by the color at color	BE (<u>Eddie Hanco</u>					evere		terso	n
MAR retained 5 should notified	0	19e. INFORMANT'S NAME (Type/Print)	,		LING ADDRESS (Stree						
		Betty J. Hancoc			8 Parkwoo						
FOR TORI		1 X Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	novel from State COI	metery, cremetory			DATE		TION — Ch		
Page I dire		21. SIGNATURE OF FUNERAL SERVICE LI		arklawn	Memoria]	AND ADDRESS OF F	5/8				ryland
BALTIMORE, after death. Page 6 may be noval. moval.		Michael	2D-Cil	Ulma	7 10 E.	Deer Parl	ט k Dr	eVol E Gaith	ersbu	irg. N	ne MD. 20877
BOX 68760 ficate be executed within an hours physician and completely filled in the prior to burial, cremation, or ear ther traumatic event, the mediane	RTIFICATION	23. PART J. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	e. Contact DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A	A CONSEDUENCE	ut Worn E OP:				tory arrest		Approximate Interval Between Onset and Death
Tritten ritten	CER		d								
w requires that the deal been signed by the atta to of Health and Menta to. of Health and Millary,	MEDICAL	PART II. Other algoriticent condition Bladde C Hyperten	ancer	but not resulti	ng in the underlyi	ng cause given ir		PERFORM YES 2 [ED?	AVAIL COM OF D	E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 ND
> 0 -	ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH	YES NO	UNCERTA	N 🗆	(1	040 1 110
上午 章章	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 X ER/Out		OTHER: 4 Nursing Ho	me 5 - Residence	6 Other (S	Specify)			
11 2 55	됩	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b.	TIME OF 28c. II	JURY AT		HOW INJ	URY OCCUR	ED	
ION OF NOTING PHYS C death with Is marked	B	1 Natural 5 Pending 2 Accident Investigation	5-1-95	113		YES 2 ND	sel+-	nothic	ted 9	unst	est wound
ATTENDING ECTOR: After s after death	8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spe	icify)	/	ice	28f. LOCATI City or	ON (Street and Town, State)	Number or I	Ayrel Route I	lumber,
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is mai	<u>-</u>			17	one			ingters		WK WO	od br
DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT: If item	COMPLET		ICIAN: To the best of my know ER: On the basis of examination							euse(a) and	manner as stated.
# HG HG MAN WATTA	BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R O OO			29c. LICENSE NU	MBER	1	29d. DATE SI	GNED (Mont	h, Day, Year)
THE OF THE DE FIELD MPOR	TO 8	Dessay	3 1. Chut	Qu g		0.C.I	M.E.		► MA	Y O	4/95
, 1	=	30. NAME AND ADDRESS OF PERSON WH									
11		Dennis J. Chute, 31. DATE FILED (Month, Day, Year)	M.D. 11		N STREE	r, BALT	IMORE	, MAF	RYLAN	D 21	201
		MAY 1.0 100F	1. As in	PI							

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled writin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First,								2. DATE OF		AY	YEAR	3. TIME OF DEATH
			Haeussler						May .	5, 19̈́		TEAR	10:30 p M
	4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (in y	rs. last birthday)	IF UNE	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	BIRTH		8. BIRTH	PLACE (State or Foreign
	050.22.3762	.22.3/62 1 May 5, 1919 Puerto									to Rico		
DIRECTOR	Holy Cros	s Hos	SE SOSIII SI SERII										
딥	RESIDENCE OF DEC	10b. COUNTY			100 01	TO TOWN	N OR LOCA	TION					10d. INSIDE CITY
5	Maryland	Monto	gomery				Spri					1	LIMITS?
	10e. STREET AND NUMBER	Hone	Somery		1311	vel		M. ZIP CODE			10a. CI1	IZEN OF W	YES 2 NO
FUNERAL	5905 Bradle	y Blvd	1.					20814				U.S.A	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1			1	3. WAS DE	CENDENT OF HISPA	NIC ORIGIN?	Specify Yes		14. RACE	— American Indian, White, etc.
ВУ	1 Never Merried 2 3 Vidowed 4 Divo		IF YES, GIVE W					pecify Cuben, Mexica S 2 NO Space	uerto	nn, etc.)	n	Specif	,
	15. DEC	EDENT'S EDUC	CATION	100	n. DECEDENT'S	LAUSILE	OCCUPAT		- V				wiitte
	(Specify only Elementary/Secondary (0	highest grade	completed) College (1-4 or 5 +		(Give kind of life. Do NOT u	work don	ne durina m	ost of working	166. K	IND OF BUS	SINESS/IN	DUSTRY	
P	12	-12/	College (1-4 or 5+		Homema	ker				Own 1	Home		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMARY 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16. KIND OF BUSINESS/INDUSTRY OWN Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)													
BE (Alfred Wilhelm Haeussler Maria De Anca												
0	19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION — City of Town State												
	1 Burist 2 Cremetion 3 Removel from State 2 Cremetion 5 Date 20c. LOCATION — City or Town, State 2 Cremetion 5 Date 20c. LOCATION — City or Town, State Date 20c. LOCATION — City or Town, State Date 20c. LOCATION — City or Town, State Date												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH Gawler's Sons							Sone					
1	5130 WI Ave. N.W. Washington D.C. 20												
	23. PARTUEnter the di	seases, or c	complications that	caused the	e death. Do						_		Approximate
	ahock, or he IMMEDIATE CAUSE (Fin	part fallure. I	List only one cau	se on each	line.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		o o roup.	atory at	rout,	interval Between Onset and Death
	disease or condition	→	High G	rade 1	Non-Ho	lgki	n's	Lymphoma					2 weeks
	reacting in deating	,	DUE TO	OR AS A CO	NSEOUENCE O	F):							
ჳ	Sequentially list conditi	000	b										
¥	if any, leading to immed cause. Enter UNDERLY	liate	DUE TO	OR AS A CO	NSEQUENCE O	P):							
윤	CAUSE (Disease or inju- that initiated events		DUE TO	OR AS A CO	NSEOUENCE O	F):							
CERTIFICATION	resulting in death) LAS	r e	1;										
	PART II. Other aignifica	nt condition	a contributing to	death but r	not reauiting	in the	underivir	o cause given in	Part i 2	Ia. WAS AN	AUTODEV	245	WERE AUTOPSY FINDINGS
EDICAL	Pancytopen							g cadao giren in		PERFOR	MED?	240.	AWAILABLE PRIOR TO COMPLETION OF CAUSE
MED									_ '	☐ YES 2	ZENO		DF DEATH?
	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF D	DEATH Y	ES 🗆	NO ¥	UNCERTAI					
등	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		PLACE OF DEA	TH (Chec	ck only one						
BY PHYSICIAN:	1 TES 2 NO		1 A Inpatient 2				luming Ho	ne 5 🗆 Residence	8 Other (S	Specify)			
퓝	27. MANNER OF DEATH	Pending	28e. DATE OF (Month, Da		28b. TIN	JURY	W	JURY AT ORK?	28d. DESCF	IBE HOW I	NJURY OC	CURED	
68	2 Suinte	nvestigation	28e. PLACE OF	F INJURY /	At home, farm	straet to		YES 2 NO	201 LOCATI	ON (Street)	and Mumbin	e or Domi D	oute Number,
		Could not be setermined	building,	etc. (Specify)					City or	Town, State)	ino ivambo	O NOTE IN	oute Number,
۳	29e. CERTIFIER (Check only	IFYINO PHYSIC	CIAN: To the best of	my knowledge	e, death occurr	ed at the	time, det	end place, and due	to the cause	(e) and man	uner ee ete	ted	
COMPLETED													and manner as stated.
	29b. SIONATURE AND TITLE	OF CENTINES						29c. LICENSE NUI	MBER		29d. OAT	E SIGNED	(Month, Day, Year)
TO BE	ann o	1	> M	2				D29675			► Ma	ay 6,	1995
	30. NAME AND ADDRESS OF Ralph Bocc						Dr	Rockvil	lo Ma				
	31. OATE FILED (Month, Day,		J2. REGISTRAI			1561	DI.	NOCKVII.	ie, MO	•			
	MAY 0	8 1995											1
			()	2 22.45	and the								OHMH-16 Rev 1/89

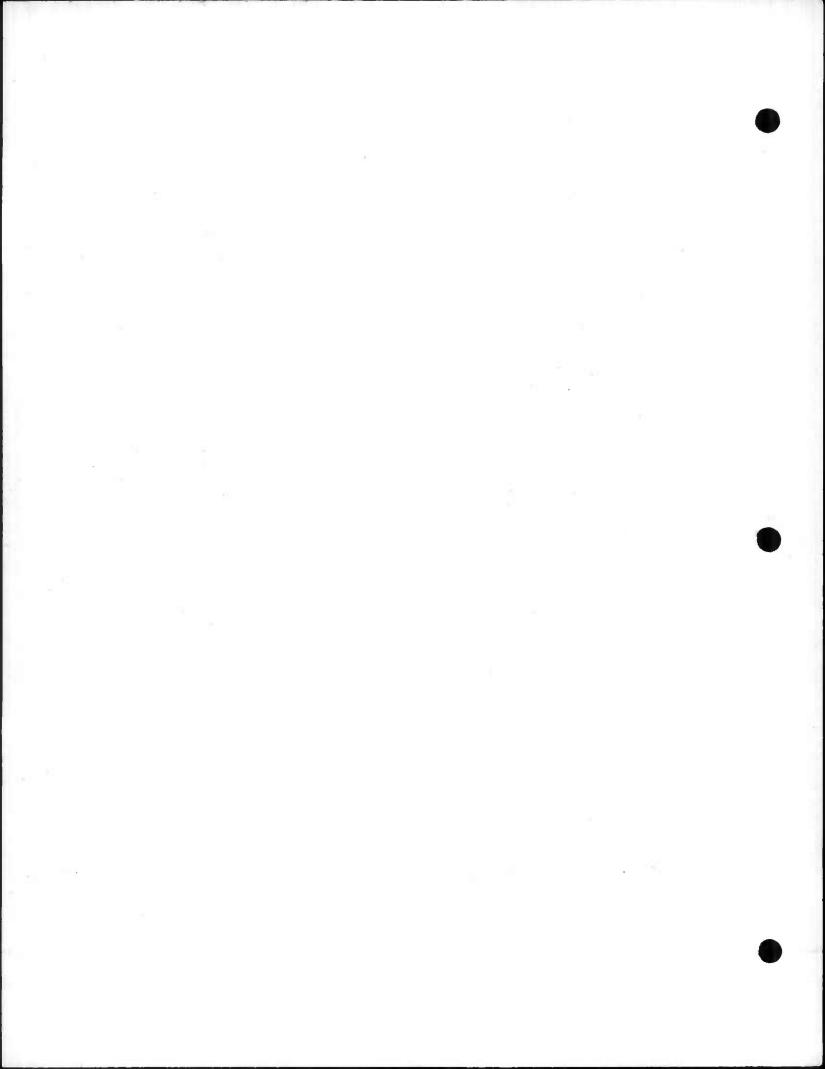
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46	certificate be executed within 24 hours after death. Page 6 may be retained by the hos
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	NG
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)				DEATH	2. DATE OF DEATH			3. TIME OF DEATH
	Paul	E. Hubanks					195	YEAR	8:15 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		O. BIRTHP	PLACE (State or Foreign
Ì	397-09-2621	1½ M 2 □ F	80 YRS.	ONTHS DAYS	HOURS MIN.	(Mornth, Day, Year) May 24, 1		Country)	onsin
	9s. FACILITY NAME (If not institution, give stre	et and number)	1	Db. CITY, TOWN C	R LOCATION OF D		9c. COUNT		
OR	15801 Avery Road				ckville			tgome	
DIRECTOR	RESIDENCE OF DECEDENT						11011		
RE	10s. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?
ā		ontgomery		Roo	ckville				1 TES 2 NO
3AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZ	EN OF W	HAT COUNTRY?
FUNERAL	15801 Avery Road				20855		Unite	ed St	tates
E.	11. MARITAL STATUS 1 Never Married 2 X Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Years, Puerto Ricen, atc.)	s or No—	14. RACE - Block.	- American Indian, White, atc.
B	3 Widowed 4 Divorced	IF YES, QIVE WAR OR DA			2 NO Specif			Specify	
	15. DECEDENT'S EDUCA	TION I	16a. DECEDENT'S US	PILAL OCCUPATIO		16b, KIND OF BU			White
	(Specify only highest grade or	ompleted)	(Give kind of wor	rk done durina mo:	st of working	Departm		7	
1	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Chemis	st.		_	gricul		2
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		011011121		18 MOTHER'S NA	ME (First, Middle, Meider	-	LCGI	_
	Charles	Hubanks				arlotte Ha			
8	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DORESS (Street a		Route Number, City or Tox		Corde)	
2	Valerie A. Hubanks					oad, Layto			MD 20882
	20s. METHOD OF DISPOSITION								
	1 Suriei X Cremation 3 Remov.	al from State	PLACE AND DATE OF or other of the ntgomery	rplece) Ma	y 8, 199	5 Bet			ryland
	21. BIGHATURE-OF FUNERAL BERVICE LICES		regomery	22. NAME AN	D ADDRESS OF FA	gurrenhert			ey Funeral
	91:1.6	1/							tgomery Ave
_	- Mille (7	- Dulla	M00348	Rockvi	lle, Ma:	ryland 20	850-28	305	egomery nive
	23. PART I. Enter the diseases, or collaboration abock, or heart failure. Li	mplications that caused at only one cause on as	the death. Do not ich line.	antar tha mo	da of dying, auc	h as cardiac or reap	iratory arre	at,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition								Onset and Death
	resulting in death)	Congestiv		ailure					1 Hour
			CONSEQUENCE OF):						
8	Sequentially list conditions, b.	Aortic Va		se					6 Months
F	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):						i l
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
Ē	resulting in death) LAST		ounded of j.						i I
CERTIFICATION	d.								1
AL	PART II. Other algnificant conditions	contributing to death be	it not resulting in	the underlying	cause given in	Part I. 24s. WAS AN			WERE AUTOPSY FINDINGS
8	Post Pericardiotom	y Syndrome,	Renal F	ailure,		1 _ YES :			COMPLETION OF CAUSE OF DEATH?
ME	Coronary Artery Di	sease					-91		YES 2XXNO
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	□ NO 🖾	UNCERTAII	v 🗆			- 161
NA N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		8. PLACE OF DEATH	(Check only one)					
PHYSICIAN: MEDIC	The state of the s	OSPITAL:		THER: Nursing Home	5X Residence	6 Other (Specify)			
E	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME C	OF 28c, INJU	JRY AT	28d. DESCRIBE HOW	INJURY OCCU	IREO	
BY	1 Natural 5 Pending 2 Accident Investigation	(11211)	1,000		ES 2 NO				
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Speci	At home, ferm, stre	et, factory, office		28f. LOCATION (Street City or Town, State		r Rural Roo	ute Number,
	4 Homicide determined					City of 10W11, Glate,	·		
2	29s. CERTIFIER 1X CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, death occurred	at the time, data	and place, and dus	to the cause(s) and ma	nner es stated	1.	
COMPLETED	000) 2 MEDICAL EXAMINER:								and manner as atated.
	29b. SIGNATURE AND TITLE OF CENTIFIER	10			29c. LICENSE NUI				Month, Day, Year)
H	Polest L	all MI)		D29300				1995
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pr	rint)	223300		Hay	, ,	1775
	Robert L. Gold, M.				#201.	Rockville.	MD 20	0850	
	MAY 0 9 1995	Julia d'avelse	or Kardall						1

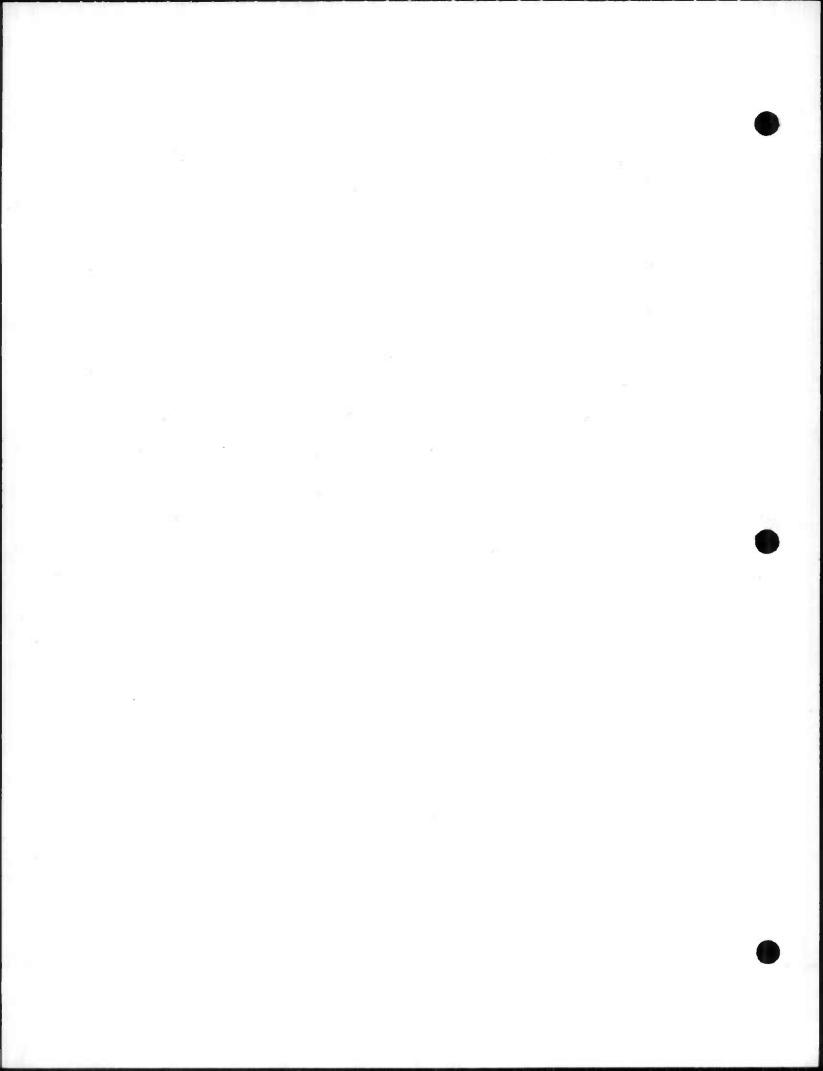


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH torver MON 3:45 P. w 107 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 X M 2 - F DAYS HOURS 577-24-0070 Nov. 5. Washington, D.C Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14635 Bauer Drive, #120 Rockville Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 TYES 2 NO permit, FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? ysician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit prior to burial, cremation, or removal. 14635 Bauer Drive, #120 20853 United States hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuban, Maxican, Puarto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puarto Ri 1 Never Married 2 Married BY 3 Widowed 4 N Divorced White 18a. DECEDENT'S USUAL OCCUPATION
172-lone kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 5 + Accountant/Bond Broker Municipal Finance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 70 Harvey M. Heckman, Sarah Hamm BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Stephen C. Heckman 9223 SW 130th Street, Miami (son) Florida 33176 9 20a, METHOD OF DISPOSITION
XIX Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must metery, crematory or other place) Glenwood Cemetery 4 Donation 5 Other (Specify) 5-8 Washington, D.C. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A. Celen 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition 100 resulting in death) traumatic event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician Mental Hygiene prior to requires that the death certificate be other QUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ŏ PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY n signed by the Health and N эпу 1 TES 2 NO OF DEATH? Shows 1 YES 2 NO t, of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. OR ATTENDING PHYSICIAN: The law 33 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate h HOSPITAL OTHER: 1 TES 2 DO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ng Home 5 Realdence 6 - Other (Specify) 9 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY After 1 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 69 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: 4 Homicide 29a. CERTIFIER TEX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as atlated. TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: II II (Check only one) HOSPITAL MEDICAL EXAMINER: On ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 256. SIGNATURE AND TITYS 29c. LICENSE NUMBER BE 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAP'S SIGNATURES
Julia Danulson Randall

31. DATE EILED

09



DIVISION OF VITAL RECORDS, P.O. BOX 68760 & BALTIMORE, MARYLAND 21215-0020

K	TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within a mount's after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	he State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	APORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certi-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or oth	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)		,			2. DATE OF DEATH		3. TIME OF DEATH
	CATHERINE	5. 1	HATHA	WAY		MAY	AY Y	S-2324 M
	4. SOCIAL SECURITY NUMBER			UNDER 1 FEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	225=05=4992 9a. FACILITY NAME (If not institution, give si	1 M 2 X F 8]	YRS.	b. CITY, TOWN O	HOURS MIN.	AUG. 1,1	913	VIRGINIA
TOR	SUBURBAN HOSP	ITAL		BETH	HESDA			TGOMERY
DIRECTOR	MD MO	, NTGOMERY	10c. CITY, T	OWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	5903 JARVI	S LA.			20814		1	J.S.A.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECI	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye		RACE American Indian.
BY	1 Never Married 2X Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 IX NO TES	If yes, spe	ecify Cuban, Mexico 2 NO Speci	an, Puerto Ricen, etc.)		Black, While, etc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S US	done during mos	N et of working	16b. KIND OF BU	SINESS/INDUS	TRY
Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	etired.)				
M	AT SATISFAIR MARKE OF A AND A	4	RETS	ALESPE			YCLOPI	EDIA
	17. FATHER'S NAME (First, Middle, Last)	TT CMT			18. MOTHER'S NA	ME (First, Middle, Maider		
8	JOHN WI] 19a. INFORMANT'S NAME (Type/Print)	LL SMITH				MARY	NORF	
2		ATHAWAY	SAME			Route Number, City or Tov	vn, State, Zip Co	de)
			PLACE AND DATE OF D	AS		#10		207-10-20-00-00-00-00-00-00-00-00-00-00-00-00
	20e. METHOD OF DISPOSITION 1	oval Irom State ceme	tery, crematory or other CHAMBERS	place)	MOD37	_ /= -	CATION — City	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	IMMBERS		D ADDRESS OF FA	CILITY		DALE, MD.
	M.M. Ch		7 M00091	W. W.	CHAMB	ERS CO.	INC.	SPRING,MD. 20910
	23. PART I. Enter the diseases, or cahock, or heart fellure. I	complications that ceused List only one cause on as	the death. Do not ch line.	enter the mod	da of dying, auc	h as cardiac or resp	iratory arrest	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death
	resulting in death)	DUE TO (OR AS A	EREBR	AL	HE	MORRH	AGE	8 HRS
		FALL						
O	Sequentially list conditions,	M	CONSEQUENCE OF:					
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING	55						i
F	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
FRT	reaulting in death) LAST	J						
	PART II. Other algnificant conditions	a contributing to death by	t not reculting in t	ho medodulos	anna alice te			
CAL	TATT III. Other alignment conditions	a contributing to death bu	t not resulting in t	ne undariying	cause given in	Part I. 24s. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC						1 TES :	1 DINO	COMPLETION DF CAUSE DF DEATH?
Σ	DID TOBACCO USE CONTR	DIBLITE TO CALISE OF	DEATH VEC		LINICEDTAN			1 TES 2 NO
AN	25, WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH (UNCERTAIL	иП		
SIC	EXAMINER?	HOSFITAL:	_ 0	THER:				
H	27. MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME O	F 28c, INJU	JRY AT	8 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCUR	ED.
ВУ Р	1 Netural 5 Pending	(Month, Day, Year) MIRY 8 9	INJURY P		ES 2 NO		NW	STEPS
0	n 2 seed investigation					281. LOCATION (Street	and Number or F	
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY -	- Al home, farm, atree	ol, factory, office				
TED	ACCIONIN	building, etc. (Specif	+ 0 MB	ol, factory, offica		City or Town, State,		
PLETED	3 Sulcide 8 Could not be 4 Hornicide determined	building, etc. (Specif	tome		and place, and due	City or Town, State		
OMPLETED	3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYSIC	CIAN: To the best of my knowle	+ 0 MB	t the time, data a	and place, and due	City or Town, State	nner as stated,	
E COMPLETED	3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYSIC	CIAN: To the best of my knowle	+ 0 MB	t the time, data a	ath occured at the	City or Town, State	nner as stated,	use(a) and manner as stated.
BE	3 Sulcide 4 Homicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINES	CIAN: To the best of my knowle	+ 0 MB	t the time, data a	and place, and due at hoccured at the 29c. LICENSE NUI	City or Town, State	nner as stated,	
	3 Sulcide 4 Homicide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINES	Duilding, etc. (Specifical Control of the basis of examination	dge, death occurred a	t the lime, data on my opinion, de	ath occured at the	City or Town, State	nner as stated,	use(a) and manner as stated.
BE	3 Sulcide 4 Homicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES	Duilding, etc. (Specifical Control of the basis of examination	dge, death occurred a and/or investigation, in	t the fime, data on my opinion, de	ath occured at the	City or Town, State	nner as stated,	use(a) and manner as stated.
BE	3 Sulcide 4 Homicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES 30. NAME AND ADDRESS OF PERSON WHO	Duilding, etc. (Specifical Control of the basis of examination	dge, death occurred a and/or investigation, in the (ITEM 27) (Type, Print C R N W C	t the fime, data on my opinion, de	ath occured at the	City or Town, State	nner as stated,	use(a) and manner as stated.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE

2

											95	5 1	5947
	1 - FOR STATE REGISTRAR		STATE OF N	MARYLAN	D / DEPA CERTIF	RTMEN	NT OF	HEALTH AND	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, EDWARD	Last)		HAMILT	ON				2. DATE MONT MAY		19	YEAR	3. TIME OF DEATH 7:15 P M
	4. SOCIAL SECURITY NUMBER		5. SEX		. last birthday)	_	DER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	10	6. BIRTHP	LACE (State or Foreign
	099-24-1770 9e. FACILITY NAME (If not institution,		1 M 2 F	62	YRS.	MONTH		OR LOCATION OF DE	Sep	t 21, 19			York
DIRECTOR	Fox Chase Rehat	8		Cente	r			Spring	CAIR			NTY OF DE.	
E	10a. STATE 10b. CI				10c. CI	TY, TOWN	N OR LOC	ATION					10d, INSIDE CITY
	New York Nas	ssau			Me	erri	ck						LIMITS?
AL	10e. STREET AND NUMBER						1	Of. ZIP CODE			10g. CIT	IZEN OF WI	HAT COUNTRY?
Ä	1772 Princeton	Pla	ce					11566			Uni	ted S	tates
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	1	FORCES? 1 IF YES, GIVE W 1952-1	X YES 2	NO	1:	ii yes, s	CENDENT OF HISPAN pecify Cuban, Maxica S 2 X NO Specifi	in, Puerto	N? (Specify Yea Rican, etc.)	or No-	14. RACE Black, Specify	- American Indian, Whita, etc. White
	15. DECEDENT'S (Specify only highest	EDUCAT	TION		DECEDENT	SUSUAL	OCCUPAT	ION	168	b. KIND OF BUS	INESS/INC	DUSTRY	WII 100
COMPLETED	Elementary/Secondary (0-12)	ī	College (1-4 or 5		ille. Do NOT (aster	use retired	1.)	ost of working		U.S. A	:- F		
MO	17. FATHER'S NAME (First, Middle, Le:	st)		14	ascer	Jer	yeam	18. MOTHER'S NA	_			orce	
	Edward		Ha	amilto	n			Catheri		INICOTO, INICOTO	ourname,	McLo	ughlin
BE C	19a. INFORMANT'S NAME (Type/Print)					G ADDRE	SS (Street	and Number or Rural		nber, City or Town	n, Stete, Zip		ognizin
2	Sherman Hamilto	n			Same	as i	#10						
	20a, METHOD OF DISPOSITION Comparison 2 Cremation 3 Comparison 2 Cremation 3 Comparison 3 Control (Specify)		al from State	206. PLA cemetery Gre	CE AND DATE , crematory or enfiel	of DISPO	osition (P enete	ery	5-1	12 Hem		City or Tow	
	21. SIGNATURE OF FUNERAL SERVI	CE LICEN	SEE /			2: F	Rapp	Funeral	Serv	ices,	P.A.		
	22 PAGY Enter the diseases	5.6	W		00827		933 (Gist Ave,	Sil	ver Sp	ring,	, MD	20910
	23. PART I. Enter the diseases ahock, or heart fal IMMEDIATE CAUSE (Final	lure. Lis	st only ona cau	se on each	ideath. Do ilna.	not ent	er the m	ode of dying, auc	h aa can	diac or reapi	ratory arr	raat,	Approximata interval Batween Onset and Death
	disease or condition resulting in desth)	a. ,	Maligna	ont Me									9 Mo's
TION	Sequentially list conditions, if any, leading to immediate	Б		(OR AS A CO		,							
ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	с.	DUE TO	(OR AS A CO	ISEOUENCE (XF):							-
	resulting in death) LAST	d											
MEDICAL C	PART II. Other aignificant cond	ditions	contributing to	death but n	ot resulting	in that	underlyk	ng causa given in	Part i.	24a. WAS AN PERFOR	MED?	1	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME											•	- 1	YES 2X NO
	DID TOBACCO USE CO	_	BUTE TO CA	USE OF D	EATH Y	ES 🗌	NO [UNCERTAIN	N 🔲				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 X NO	-	IOSPITAL:		LACE OF DEA	ОТН	ER:	ne 5 🗆 Rasidence	* \(\sigma_{\text{in}} \)	. (0			
Ť	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. Til	WE OF	28c. IN	JURY AT	_	SCRIBE HOW II	JURY OC	CURED	
ВУР	1 X Natural 5 Pending 2 Accident Investigs	tion	(Month, D	шу, төшг)	"	JURY M		ORK? YES 2 NO					
	3 Suicide 8 Could no 4 Homicide detarmin	ot be	28a. PLACE O building,	F INJURY — A etc. (Specify)	t home, farm,	street, ta	ictory, offi	Ce .	28f. LOC City	CATION (Street a or Town, State)	nd Number	or Rural Ro	ute Number,
COMPLETED								a and place, and due death occured at the					and manner as stated.

2309 Shorefield Road, Wheaton,

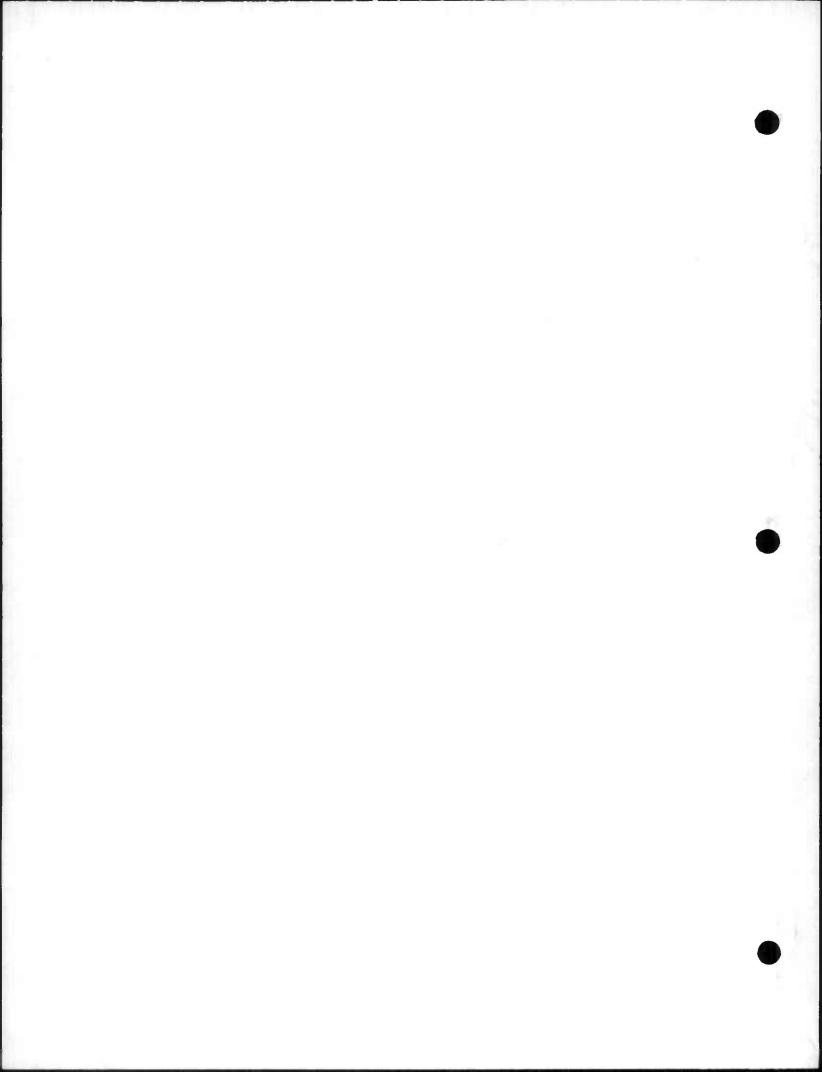
29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D 01120 May 10, 1995

WHO COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print)

Walter E. Goozh, M.D. 31. DATE FILED (Month, Day, Year)
MAY 11

32. GEGISTHAR'S GIGNATURE Filia Dawelson Rawlall

DHMH-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local death. Page 6 may be retained by the hospital or attending physician.

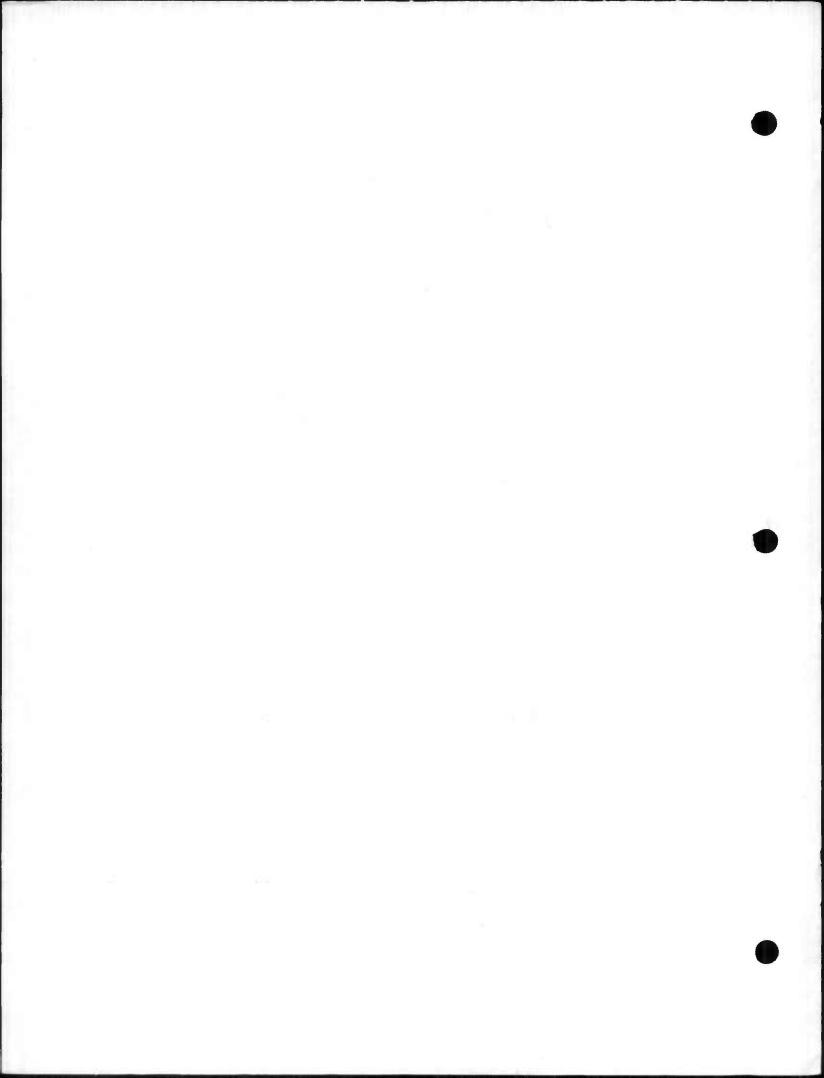
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 tours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						10/11	- 01	047		nu	G. NO.			
	1. DECEDENT'S NAME (First		en-Ho Hsu							2. DATE OF DI MONTH May 9	DAY	95	YEAR	3. TIME OF DEATH 9:03 Å M
	4. SOCIAL SECURITY NUME	BER .	5. SEX	6. AGE (In vi	s. lest birthday)	JE UND	ER t YEAR	IF UNDER	24 HDS	7. DATE OF BI			A BARTHO	PLACE (State or Foreign
	217-35-6377										1,19	59	Country)
	Se. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CI	TY, TOWN	OR LOCATI	ON OF DE		1/13		NTY OF DE	
<u>ج</u> ا	Potomac Val	ley Nu	arsing Ho	sing Home Rockville Montgome									gomerv	
ق ا	RESIDENCE OF DEC	10b. COUNT												
DIRECTOR					10c. CI		OR LOCA						- 1	10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER		ontgomery			R		rille	-			40- OIT		1 YES 2 NO
A I	10201 Nolan		2				- 1		850				iwan	
FUNERAL	11. MARITAL STATUS	DITTO	12. WAS DECEDEN			13	3. WAS DE			IC ORIGIN? (Spi	ecify Yes o			
	1 Never Married 2 Married FORCES? 1 YES 2 NO II yes, specify Cuben, Maxican, Puerto Rican, etc.)								— American Indian, White, etc.					
D 8√	3 Widowed 4 Divo												-,,	Asian
	(Specify onl	EDENT'S EDU y highest grade	CATION completed)	16	(Give kind of	work don	e during m		ng	16b. KIND	OF BUSI	NESS/IND	USTRY	
COMPLETE	Elementary/Secondary (6	3-12)	College (1-4 or 5	-)	Mecha Mecha		,			7	.	16 d 7 d		
8	17. FATHER'S NAME (First, M	liddle, Last)			Mecna	anic	-	16 MOT	HED'C NAI	AE (First, Middle,	tomo.	_	:	
		Cheng-	-Lung					10. 11011		i Wang		urneme)		
BE	19e. INFORMANT'S NAME (Type/Print)		-	19b. MAILING	ADDRE	SS (Street	end Number		loute Number, Cit		State, Zip	Code)	
임	Yen-Yen Chi	.ao			10201	l No	lan	Drive	, Ro	ckvill	e, M	aryl	and	20850
	20e. METHOD OF DISPOSIT		oval from State	20b. PL	ACE AND DATE y, crematory or c LGOMEY	OF DISPO	OSITION (A	leme of 2	1995	DATE	20c. LOCA	ATION —	City or Tow	rn, State
į	4 Donation 5 Other	(Specify)		Mon	tgomery	z Cr	emat	oriun	n, Ir	ic.	Beth	esda	, Ma	ryland
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	_		22 H	OME /	ROCKS	ss of fac 7ille	Robe Inc.	rt A	. Pu	mphr	ey Funeral
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805													
	23. PART I. Enter the d shock, or h	iseesea, or e eart feilure.	complications tha	t caused the	e death. Do	not ente	er the m	ode of dy	ing, auch	as cerdiac o	or reapire	itory arr	eat,	Approximate interval Between
l	IMMEDIATE CAUSE (Findiseese or condition	nal	1		4	1.								Onset and Death
	resulting in death)	→	· Car	cugn	a g	/lle	fren	1						242
_ [DUE TO	(OR AS A CO	NSEOVENCE O	IF):								
<u></u>	Sequentially list condit		b DUE TO	(OR AS A CO	NSEQUENCE O	rF):								
ERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or Inju	ING	C.											1
	that initiated events		DUE TO	(OR AS A CO	NSEOUENCE O	F):						-		
ER	resulting in death) LAS	" (d											
<u> </u>	PART II. Other eignifice	int condition	a contributing to	death but r	not resulting	In tha i	underlyir	ng ceuse (given in	Part I. 24a.	WAS AN A			WERE AUTOPSY FINDINGS
DICAL	\mathcal{L}	lego.	unclas	Ofer (andu	· CK	2-010	ude	100		PERFORM YES 2	1	'	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME														1 - YES 27 NO
	DID TOBACCO	USE C	CONTRIBUTE	TO CA	USE OF	DEA	TH Y	ES 🗆	NO					***
<u>5</u>	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			ОТН		PLACE OF D	EATH (Che	ck only one)				
PHYSICIAN:	1 YES 2 DATO		1 Inpatient 2	-		410 M	ursing Ho		sidence	6 Other (Spe				
		Pending	28e. DATE OF (Month, D		26b. TIN	JURY M	W	IJURY AT ORK? YES 2	¬ NO	28d. DEŞCRIBI	E HOW IN	JURY OCC	CURED	
B	2 Culate	Investigation	28a. PLACE O	F INJURY —	At home, farm,	street, te			NO	261. LOCATION	(Street en	d Number	or Pural Po	nuto Mumbar
		Could not be determined	building,	atc. (Specify)			,,			City or Tow		o momoo	OF FIGURE 710	ute Namber,
MPLE	290. CERTIFIER	TIFYING PHYSI	CIAN: To the best of	mu koowlede	e deeth occum	and at the	alma des				ide mali	4.5570	· ·	
	anal .													end manner ee stated.
8	29b. SIGNATURE AND TITLE		0 //			-		_	ENSE NUM					(Month, Day,-Year)
1 a	Muson	K.	Souk	110	111)			DO	667	2/		▶ 9	18 /4	
일	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type	, Print)		12.					1-//	
	Myron L. Le			09 Sh	orefiel	ld R	oad,	Whea	ton,	Maryl	and	209	02	
	31. DATE FILED (MONTH DOY)	1 100	32. REGISTRA	R'S SIGNATU	RE									
	. ורוווו	1 199) julia d	iwalior	Rardall									



8. BIRTHPLACE (State or Foreign Country) Georgia

14. RACE — American Indian, Black, White, atc.

Home/ 7557 Wisconsin 20814-3501

Approximate

1 TYES 2 T NO

Onset and Death

3. TIME OF DEATH

1 YES 2 NO

45 P.

permit. Pages 1, 2, 3 should has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law in THE FUNERAL DIRECTOR: After this certificate has be fried within 72 hours after death with the State Dept. IMPORTANT: If item 28 is marked, or item 23 s.

DIRECTOR

FUNERAL

BY

BE COMPLETED

pe

must

examiner

medical

the

other traumatic event,

10

Item 23 shows any Injury,

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

ETED.

COMPL

BE

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1 - FOR STATE REGISTRAR		STATE OF M	IARYLAN	D / DEPA	RTMEN	T OF I	HEALTH /	AND I	MENTAL HYGIEN REG. NO	_		
1. DECEDENT'S NAME (First	t, Middle, Last)	Edith		+	HER	RNA	NDE	2	2. DATE OF DEATH	3	YEAR	3. TIME OF DE
4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In y	rs. last birthday		R 1 YEAR	IF UNDER 2	4 HRS.	7. DATE OF BIRTH		a. BIRTH	IPLACE (State or I
577-48-92	18	1 M 2 X F	9	3 YRS.	MONTHS	DAYS	HOURS	MIN.	(Mornth, Day, Year) Sept. 18,	1901	Countr	η orgia
9a. FACILITY NAME (If not it	stitution, give :	street and number)			9b. CIT	Y, TOWN	OR LOCATION	N OF DE		_	NTY OF D	
Suburban	Hospi	tal				ethe	sha			Ma	ntgo	moru
RESIDENCE OF DE	CEDENT				~	, 0 0110	-buu			MO	irego	mery
10a. STATE	10b. COUNT	Υ		10c, C	TY, TOWN	OR LOCA	TION					10d. INSIDE CIT
Maryland	М	ontgomery	7		Rock	vill	e					1 YES 2 %
10e. STREET AND NUMBER						10	1. ZIP CODE			10g. CIT	IZEN OF W	YHAT COUNTRY?
10201 Gro	svenor	Place					2085	2		Un	ited	States
11. MARITAL STATUS		12. WAS DECEDENT	EVER IN U.	S. ARMED	13.	WAS DEC			IIC ORIGIN? (Specify Yes			- American Inc
1 Never Married 2 3 Widowed 4 L Divo		FORCES? 1				It yes, sp	ecify Cuban, 2 & NO	Mexica: Specify	n, Puerto Rican, atc.)		Special Specia	, White, atc.
	EDENT'S EDU		16	a. DECEDENT'			ON ost of working		16b. KIND OF BUS	SINESS/INI	DUSTRY	
Elementary/Secondary (I	0-12)	College (1-4 or 5+		life. Do NOT	use retired.		or or ordinary					
		2		N	lurse	<u>:</u>			U.S.	Gove	rnmei	nt
17. FATNER'S NAME (First, M	liddle, Last)						18. MOTHE	R'S NAI	ME (First, Middle, Maiden	Sumame)		
Willard Le	eslie	Riley					Li	11i	an Lee Car	ter		
19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRES	S (Street i	^		Route Number, City or Town		Code)	
Billie An	n Hurs	on							otomac, Ma			20854
20a. METHOD OF DISPOSIT			20b. PL	ACE AND DATE		SITION /N	eme of		DATE 20c LO		City or To	
1 2 Burial 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other	(Specify)	oval from State	St.	y, cremetory or Gabri	el's	Par	lay 12 ish C	, l	995			yland
21. SIGNATURE OF SUNERA	L SERVICE LI	CENSEE			22	NAME A	ND ADDRESS	OF FAC	CILITY			
> Xh	22.	Sento		00202	Ro Be Av	bert thes enue	da-Ch Bet	ump evy hes	hrey Funer Chase, In da, Maryla	al H c. 7 nd 2	ome/ 557 v	Wiscons
23. PART i. Enter the d shock, or h	seeses, or eart failure.	complications that List only one ceus	caused th	e deeth. Do	not ante	r the mo	de of dying	g, suct	as cardiec or respi	ratory sn	rest,	Approxim

Sequentially list conditions, if sny, lesding to immediate e. Enter UNDERLYING CAUSE (Disease or injury thet initiated events reaulting in death) LAST

IMMEDIATE CAUSE (Final

disease or condition resulting in death)

DUE TO	(OR AS A CONSEQUENCE OF):	
PEKIPH	TERAU ACCULAR DISEASE (OR AS A CONSEQUENCE OF):	
502 10	(on so a consequence or):	į
DUE TO	(OR AS A CONSEQUENCE OF):	

PART II. Other eignificant conditions contributing to desth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO

Acige ADETIC OCCUSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 YES 2 NO Nome 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident

28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide

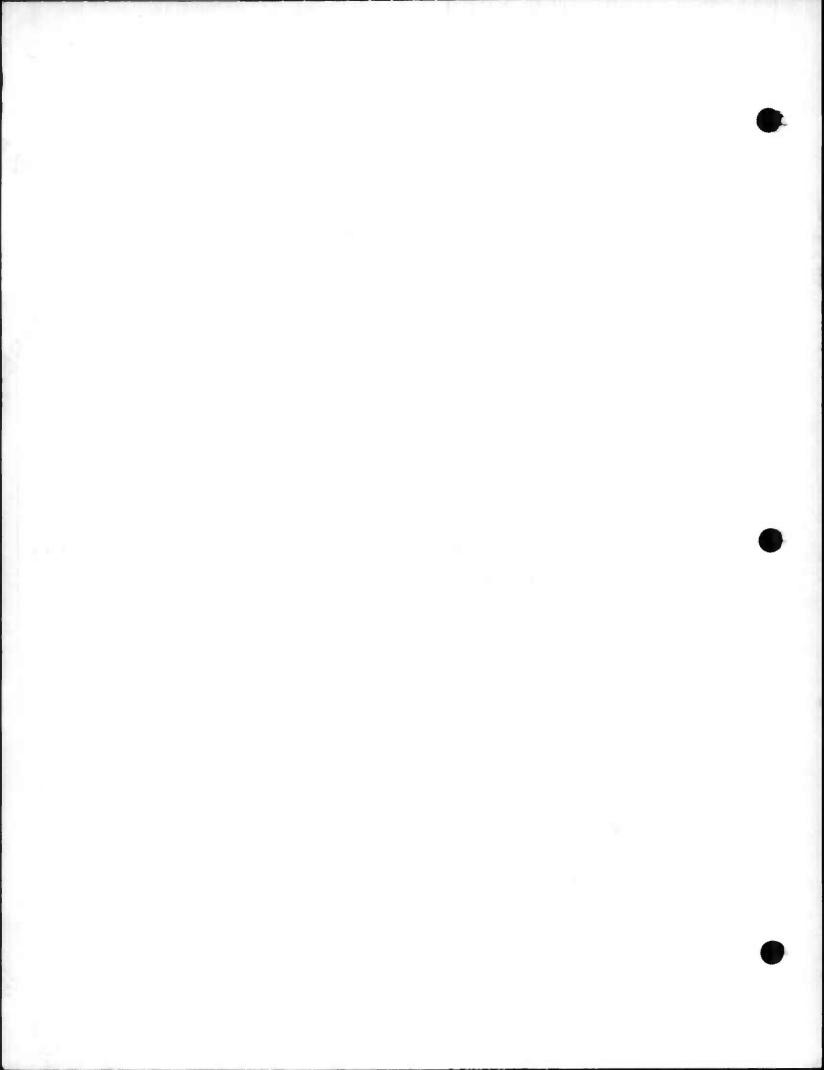
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. ation and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and menner as atated.

NNO TITLE OF CENTURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Lows 02 D23190 95

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8218 WISCONSIN AVE., BETHESDA, MD. 20814 Louis KOZLOFF, M.D.

32. REGISTRAP'S SIGNATURE
Julia Develor Randall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial. De filled within 17 hours after death with the State Dept. of Health and Mertal Hygiene prior to burial, cremation, or removal. or removal. IMPORTANT: If them 28 is marked, or them 23 shows any latiture, no other transmalls event the medical evantings must be posited.
THE CHILD IN THE PROPERTY OF T

Amended # 6 5/18/95 MRT Montgomery Cought 1950 Amended # 1, 5/15/95 MRT Montgomery Cought 1950 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE &											
A	Amended # 1, 5/15/95 MRT Monta Amery County										
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH										
11	1. DECEOENT'S NAME (First, Middle, Last)				DEATH	REG. NO.		3. TIME OF DEATH			
100	Ruth Henderson			1		May 9	1941				
	170 07 5000			IF UNDER 1 YEAR MONTHS DAYS	Month Day Year) (Country)						
DIRECTOR	10211			SP CITY TOWN	July 26, 1917 Pennsylvania						
					Catonsville Baltimore						
	RESIDENCE OF DECEDENT										
	100.011,			onsvill				10d, INSIDE CITY LIMITS? 1 YES 2 NO			
	10e. STREET AND NUMBER				101. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	715 Maiden Choice Lane				21228			USA			
F.	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			13. WAS DE	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell 1996, specify Cuben, Maxican, Puerto Rican, etc.)			e or No 14. RACE American Indien, Black, White, atc.			
B	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES				1 Tes 2 No Specify:			Specify: White			
ED	15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S	USUAL OCCUPAT	ON pet of working	16b. KIND OF BUS	b. KIND OF BUSINESS/INDUSTRY				
틸	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during m se retired.)	oat or working	II C D		m			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	0	Clerk		U.S. Dept, of Trea			Treasury			
BE C	Unknown Gravel Beula McCormick										
TO B	19e. INFORMANT'S NAME (Type/Print)					loute Number, City or Town					
-	Milton T. Henderson 715 Maiden Choice Lane, Catonsville, Maryland 21228										
	206. METHOD OF DISPOSITION 1 Strict 2 Cremetion 3 Removal from State 4 Donellon 6 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of Commetery, cremetary										
	4 Donollon 6 Other (Specify) Cemetery, cremetory of other (Jace) Congressional Cemetery 5/12 Washington, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines—Rinaldi Funeral Home										
	11800 New Hampshire Avenue Silver Spring, Maryland 20904							1.00			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. Approximate interval Batween										
	IMMEDIATE CALICE (Final		Onget								
	disease or condition resulting in death) a. Chronic Obstructive Reliance VIII Property Institute of the consequence of:							1e Inyrs			
z	To ha consequence of:										
TION	Sequantially list conditions, If any, laading to immediata DUE TO (OR AS A CONSEQUENCE OF):										
FICA	CAUSE (Disease or Injury										
CERTIFICA	that initiated events resulting in death) LAST										
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 246, WERE AUTOPSY FINDINGS										
MEDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.						MED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE			
ED						OF D		OF DEATH?			
 2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)										
IXSI	1 TYES 2 NO	1 28e. DATE OF INJURY			ne 5 Residence (
	1 Natural 5 Pending		28b. TIME OF INJURY AT WORK? 1 YES 2 NO I home, farm, street, factory, office		28d. DEŞCRIBE HOW INJURY OCCURED						
D BY	2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify)				Al home, farm,	281. LOCATION (Street end Number or Rural Route Number,					
ETE	4 Homicide delarmined building, etc. (Specify)					City or Town, State)					
COMPLETE	29e. CERTIFIER (Check only 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(e) end menner as atsted.										
S	one) 2 MEOICAL EXAMINER: On the beate of examination end/or investigation, in my opinion, death occured at the time, data end place, end due to the cause(e) and manner as stated.										
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, D 3 4 0 1 - 3 NG C 6										
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (3ma	Print)	1/ 3 /		194	9,1895			

29b. SIGNATURE AND TITLE OF CERTIFIER D3401-3 29d. DATE SIGNED (Month, Day, Year) WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 701 marde Choilee Lone 21228

22 MEGISTRAN'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

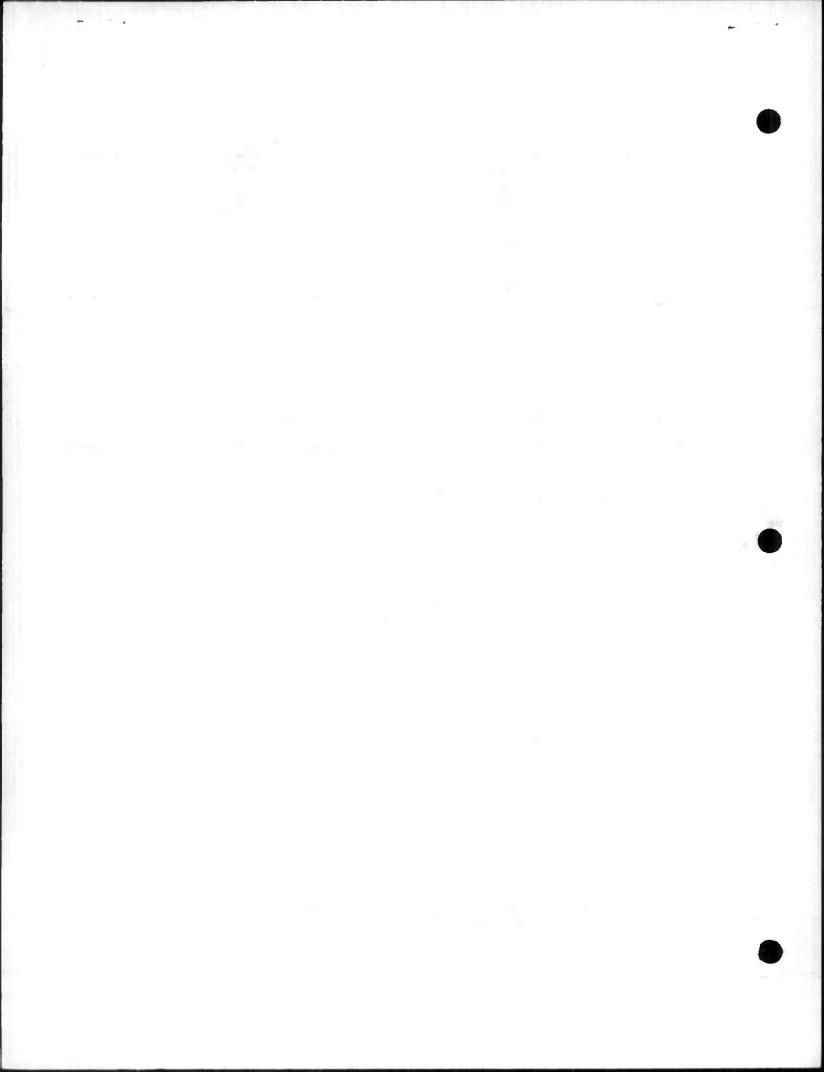
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

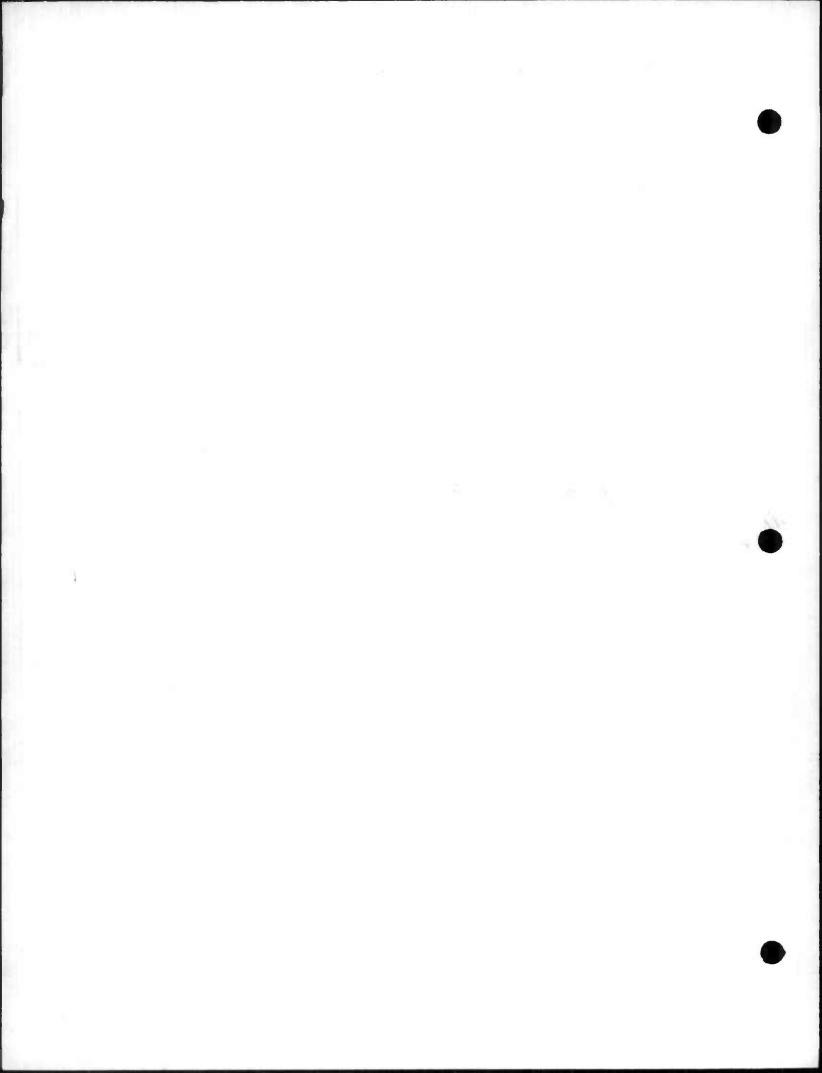
	REGISTRAR		CERTIF	ICATE U	PUEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) MARTHA NEA		ALE HEINE			2. DATE OF DEATH MONTH TOAY 1995 YEAR 1:01 a			
DIRECTOR	4. SOCIAL SECURITY NUMBER 214-16-7941		GE (In yrs. last birthday) 9 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH NOV 22 1	.915 Ma:	ATTHPLACE (State or Foreign unity).	
	9e. FACILITY NAME (If not institution, give		96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH						
	The Memorial Hospital			Easton Talbot					
입	10e. STATE 10b. COUNT	TY .	Inc. Cr	TY, TOWN OR LOC	ATION			Last manne army	
	Maryland Do		Cambridge				10d, INSIDE CITY LIMITS? 1 YES 2 NO		
BY FUNERAL	100. STREET AND NUMBER 5716 Ross Neck Rd.							• A .	
	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 20 X IF YES, GIVE WAR OR DATES			If yes,				ACE — American Indian, lack, Whita, etc.	
	15. DECEDENT'S EDI	JCATION	16a DECEDENT'S	USUAL OCCUPA	TION	165 KIND OF BU	ICINESS /INICI ISTM	,	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use refleed.) homemaker								
S	17. FATHER'S NAME (First, Middle, Last)			-	19 MOTHED'S N	AME (First Middle Malder	Cumpage		
BE C	John A. Wheeler				18. MOTHER'S NAME (First, Middle, Malden Surname) Martha Neale Wallis				
2	196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard A. Heine 5716 Ross Neck Rd., Cambridge MD 21613								
	20a. METHOO OF DISPOSITION 1 & Burtal 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of State State State Name of State State Name of State State Name of State State Name of State State Name of State State Name of State Name of State Name of State Name of State State Name of State								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home								
	Renett R Thoras 7 700 Locust St. Cambridge MD 21613								
	23. PART I. Enter the disesses, or ahock, or heart feilure. IMMEDIATE CAUSE (Finsl disesse or condition resulting in daeth)	s. Cross of	n aach lina.	resolon	g and	ch se cardisc or reap	iratory arreat,	Approximate Interval Between Onaet and Daath	
MEDICAL CERTIFICATION	Sequentially list conditions, If any, laeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	humbay	usclerin 10			AUTOPSY 2 RMED? 2 (I) NO	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO			
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES NO	UNCERTAL	N□			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:								
ΥS	1 TYES 2 THO	1/2 Inpetiant 2 ER/C		4 🗆 Nursing He	me 5 🗆 Rasidenca	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1. Natural 5 Pending 2 Accident Investigation			8b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURED			
	3 Suicide 4 Momicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, larm, a building, etc. (Specify)			treet, factory, office 281. LOCATION (Street, factory, office City or Town, Ste			et and Number or Rural Route Number, te)		
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Ilme, date end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the Ilme, date and place, and due to the cause(e) and manner as stated.								
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER WWW. TWOON 6				29c. LICENSE NUMBER			29d. DATE SIGNED (Monthy Day, Year)	
-	William H. Wood Jr. M.D. 506 Idlewild Ave., Easton MD 21601								
	MAY 0 9 199	32 AEGISTRANS S	HONOTHING WALL						



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d by	D	6
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be re	36.5	200
Thay	ba '	7
9 9	ecto	Ë
Pag	al di	ner
eath.	funer	ж
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four state death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 70 hours after death with the State Dam of Hearth and Mental Humana prior to build, remarking or according	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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10	5 M	IMP

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	CATE O	F DEATH	REG. NO		
3	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
		VERONICA		HOFFMAN	<u> </u>	MAY 14	1995	1:15 a M
	4. SOCIAL SECURITY NUMBER	The second second	(In yrs. Inst birthday)	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	8, BIRT Coun	HPLACE (State or Foreign
	212 38 5570	1 🗆 M 2 🖾 F 9.	5 YRS.	MONTHS DATE	MOONS MIN.	MARCH 10.		RYLAND
	Se. FACILITY NAME (If not institution, give				N OR LOCATION OF D		9c. COUNTY OF	DEATH
DIRECTOR	SACRED HEART HOS	PITAL		CUMBI	ERLAND		ALLEGA	NY
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	PV						
E I	MARYLAND ALLE			r, town or loo STBURG	CATION			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	JAN I	FRO					1 YES 2 NO
FUNERAL				1	101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
NE	40 LOCUST ST				21532		U.S.A	1.
5	11. MARITAL STATUS 1 Never Merried 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO			NIC ORIGIN? (Specify Year, Puerto Rican, atc.)		E — American Indian, ik, Whita, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR I	DATES		ES 2 NO Speci		Spec	WHITE
	15. DECEDENT'S EDU	ICATION	16a. DECEDENT'S	LIGUAL OCCUPA	TION	Las vena an ar	1	MILLIE
COMPLETED	(Specify only highest grad	le completed)	(Give kind of w	rork done during	most of working	166. KIND OF BU	SINESS/INDUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5 +)				DUDI TO	COMPOS	
M	17. FATNER'S NAME (First, Middle, Last)	5 + 3	TEACHE	K	District Control	PUBLIC		
		TOO TO			()	AME (First, Middle, Malden	Surname)	
BE	THOMAS A 19a, INFORMANT'S NAME (Type/Print)	. FOOTEN					sey	
2	N					Route Number, City or Tow		
	CONSTANCE HIGBEE					MAMARONECK ,		
	29a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ren	novel from State 20	b. PLACE AND DATE Of metery, cremetory or of	F DISPOSITION	(Name of	DATE 20c. LO	CATION — City or To	own, State
	4 □ Ponetion 6 □ Other (Specify)	H	ILLCREST	BURIAL			CUMBERLAN	D, MD 21502
	21. SIGNATURE OF PONERAL SERVICE LI	CIPNSEE	1		AND ADDRESS OF FA			
	> 7 / Knila.	JIV	Dupa	/ 1		L HOME, P.A		500
\neg	23. PART I. Enter the diseases, or	complications that cause	ed the death. Do n	of enter the r	MAIN SI	, FROSTBUE	retory errors	Approximata
	shock, or heart failure.	List only one cause on	each line.		node of dying, and		ratory arreat,	interval Between
	iMMEDIATE CAUSE (Final disease or condition	1 04	Tr. 0		- 0 -	T1 / 0		Onset and Death
	resulting in death)	DUE TO (OR AS	16 1229	1)(12/4	IORY	TAILU R	<u></u>	30 MINU
				~	/			4 ,
CERTIFICATION	Sequentielly list conditions,	b. DIJE TO (OR AS	A CONSEQUENCE OF	9				day
AT	if any, leading to immediate cause. Enter UNDERLYING		A GONGEOGENCE OF	,.				
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS	A CONSEDUENCE OF):				
E	resulting in death) LAST	-						j
E		d					-2	<u> </u>
	PART il. Other algnificent condition	na contributing to death	but not resulting in	n the underly	Ing ceuse given in	Part I. 246 WAS AN		. WERE AUTOPSY FINDINGS
DICAL	ARTERIOSEL	eroric Her	ART DIS	EASE	a) Hear	NT TALLUK	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
MEC	RENAL	FAILURE						OF DEATH?
	DID TOBACCO USE CONT			S D NO	LINCEDTAL	N 🗆		1 YES 2 NO
Ž	25. WAS CASE REFERRED TO MEDICAL	1	26. PLACE OF DEAT					
ဗ္ဗ	EXAMINER?	HOSPITAL:	testions 3 Dec	OTHER:		SHIP OF SHIP		
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY	26b. TIME		oma 5 Residenca	6 ☐ Other (Specify) 28d. DESCRIBE NOW I	HIDY OCCUPED	
	1 Avetural 5 Pending	(Month, Day, Year)	INJU	JRY Y	YORK?	28d. DESCHIBE NOW I	NJUHY OCCURED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJUR	V — At home form of					
₽	4 Nomicide a Could not be	building, etc. (Spe	ecify)	ireet, ractory, or	RC.	28f, LOCATION (Street I City or Town, State)	and Number or Rural I	Route Number,
	29a, CERTIFIER							
틸	(Check only	ICIAN: To the best of my know						
COMPLETED	2 MEDICAL EXAMINI	ER: On the basis of axamination	on and/or investigation	n, in my opinion	death occured at the	time, data and placa, an	d dua to the cause(s	i) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	*			29c. LICENSE NUI	MBER	29d. DATE SIGNED	(Month, Day, Year)
86	S'Char	your &			D 2.1	1638	► MAY	15 1000
2	30. NAME AND ADDRESS OF PERSON WIN	P COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type.	Print)	1 7 7 9	-10	AMAL S	21 1773
		CHANG M.D			0/10.	FROSTBUR	2 K1 10	1/40 2000
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		o unce	L-43a	TKOS BUR	4 MAK	100y -13 32
		1. 1. 1.			_			
	MAY 1 6 199	16	or renderly					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

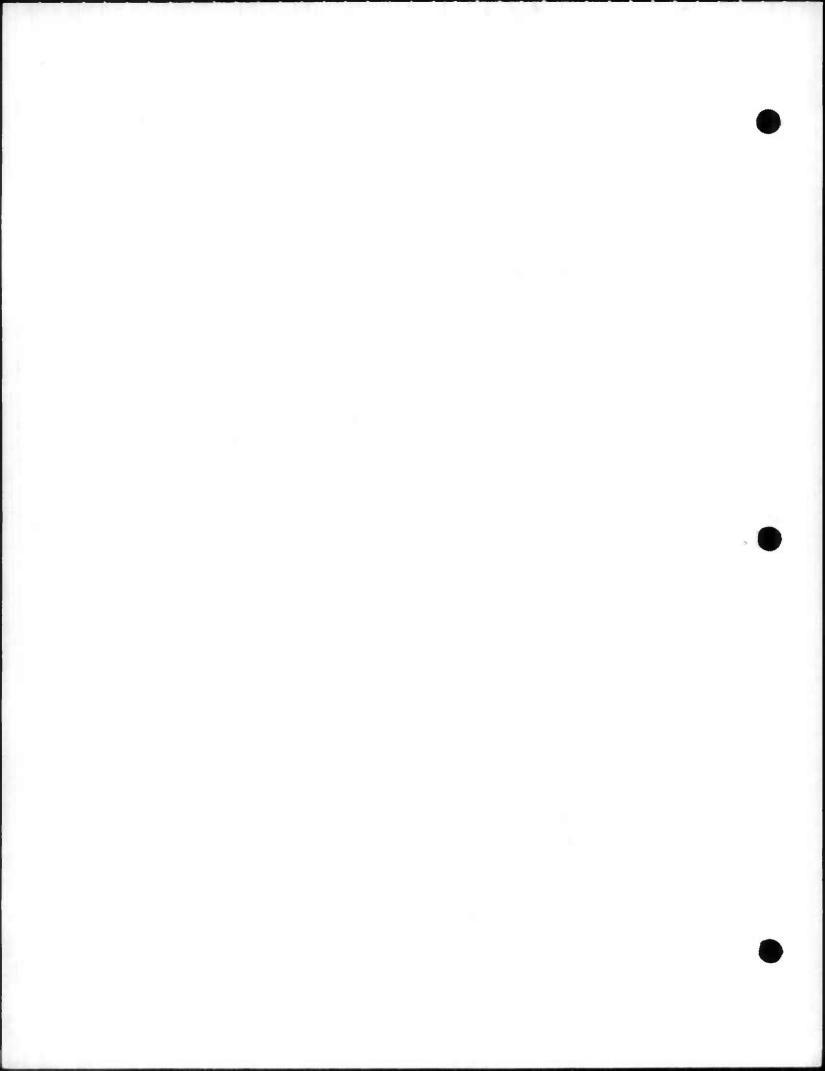
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE (F DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE O	F DEATH			3. TIME OF DE	ATN
	DONALD A	LAN	HUGHE	'S			MAY	01	1995	YEAR	2:20	Рм
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. ias		IF UNDER 1 YE	AR IF UNDER 24 HRS.	7 DATE OF	BIOTH		a BIRTI	HPI ACE /State or	Enmine
	169-56-9197	1 M 2 D F	23	YRS.	MONTHS DA		MAY	19, 1	972	PE	NNSYLVAI	NTA
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TO	VN OR LOCATION OF D		, ,	*	NTY OF D		
8	wooded area/casl	h valley r	oad		La Va	le				EGA		
5	RESIDENCE OF DECEDENT											
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION	10d. I					ry
	PA BED1	FORD		H	ZNDMAN						LIMITS?	NO
AL	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITI	ZEN OF	WHAT COUNTRY?	
FUNERAL	R. D. 1, BOX 583	3				15545			lυ	ISA		
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AF	MED	13. WAS	DECENDENT OF NISPA	NIC ORIGIN?	(Specify Yes	or No-	14. RAC	E — American Inc	dan,
	1 X Never Married 2 Married	FORCES? 1 [] IF YES, GIVE WAR		NO		, specify Cuban, Maxic YES ZXXNO Spec		an, etc.)		Spec	k, White, etc.	
B	3 Wildowed 4 Divorced					ALA CALL	.,			Орос	WHITE	
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S	USUAL OCCUP	ATION most of working	16b. K	IND OF BUS	SINESS/IND	USTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT us	e retired.)	most or wonang						
4	12			LABOR	RER		FC	OD/BI	EVERA	GE S	SERVICE	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					18. MOTHER'S N						
BEC	ROBERT W. HUGHES	5				RITA	A. DIE	ETZ				
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Str	et and Number or Rural	Route Number	City or Town	n, State, Zip	Code)		
2	RITA A. URICE					CORRIGAN			215			
	20a METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Remo		20b. PLACE	AND DATE	OF DISPOSITION	(Name of	DATE	_	CATION —		own, Stata	
	1 N Burial 2 Cremation 3 Rame 4 Donation 5 D Other (Specify)	oval from Stata	HYND!	MAN or o	EMETER	Y 5/5/	1			•	15545	
	21. BIGHATURE OF FUNERAL SERVICE LIC	SYSEE			22. NAM	E AND ADDRESS OF F	ACILITY			-	1 10040	,
	· / Milley N. Ze	e le				VEY H. ZE DMAN, PA				OME		
	23. PART I. Enter the diseases, or s	omplications that co	eused the da	ath. Do r	ot enter the	mode of dying, au	ch as cardle	c or reapl	ratory arm	eat,	Approxim	nate
	snock, or neart failure.	Let only one cause	on each line	9.					codes sais	The Late	interval f	Batween
	IMMEDIATE CAUSE (Final disease or condition	COLEA	1501	. 4 8 .	10-11-	10 017	0.14				Onset an	Daath
H	resulting in death)	DUE TO (OR	AS A COUSE	OLIENCE OF	100 mg	0000	14.671				Julint	D.
_	_	302 10 (01)	70 A 00110E	OOLNOL O								
ő	Sequentially list conditions,	DUE TO (OR	AS A CONSEC	DUENCE OF	n:							
A	If any, leading to immediate cause. Enter UNDERLYING	100			,-							
2	CAUSE (Disease or Injury that initieted events	DUE TO (OR	AS A CONSEC	OUENCE OF		· · · · · · · · · · · · · · · · · · ·						
CERTIFICATION	reaulting in death) LAST	4			100						İ	
빙											1	
- 11	PART II. Other aignificent condition	a contributing to de	eth but not r	esulting i	n the underl	ying cause given in	Part i. 2	4a. WAS AN		24b	WERE AUTOPSY	
EDICAL							Ι,	VES 2			AVAILABLE PRIOF	
J J											OF DEATN?	NO
5	DID TOBACCO USE CONTE	RIBUTE TO CAUS	E OF DEA	TH YE	S II NO	XX LINCERTAL	ΝП				1 123 2	NO
₹	25. WAS CASE REFERRED TO MEDICAL				H (Check only o		14 [
္က	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER	Mostration 0		OTHER:		- 1	-				
PHYSICIAN: M	27. MANNER OF DEATN	24a DATE OF IN I	1 PDV	28b, TIM		ioma 5 Residence		Specify) A	the state of the	No. W. A. William		
	1 Netural 5 Pending	(Month, Day,)	(bar)	UNI	URY	WORK?					SELF	
à	2 Accident Investigation											
	3 Suicide 6 Could not be 4 Nomicide determined	28a. PLACE OF IN building, etc.	(Specify)	me, farm, s	treet, lectory, o	ffice	City or	Town, Stete)			Poute Number,	
		Woo	05				bina	y mou	NEW IN	OVI	reduty (OMO
COMPLETED	(Check only 1 CERTIFYING PHYSIC	CIAN: To the beat of my	knowledge, de	ath occurre	d at the time,	late and place, and du	to the cause	(a) and man	ner as state	ıd.		
8	2 MEDICAL EXAMINE	R: On the basia of exami	ination end/or i	Investigatio	n, in my opinia	n, death occured at the	time, date an	d place, and	d dua to the	CRUSO(S) end manner aa	stated.
O I	296. AIGNATURE AND TITLE OF CERTIFIER	1				29c. LICENSE NU	MBER	T	29d, DATE	SIGNED	(Month, Day, Year))
∞ ∥	Mary To Day	46,18				O.C.M.		- 1			,1995	
ဥ	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATN (ITF	M 27) (Type	Print)	1 0.0					,	
	MARIAMOR K					,BALTIMORI	Z_MARV	T.AND	21201	1		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S		TITATA (Litibil	LE TOTAL	JERTIL.	TK NEATS	2120	-		
	MAY 0 5 10	- A. A		1 4								
- 11	700 TO 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	13 June Clay	William C	Mall								

DOMESTIC DESIGNATION OF THE PROPERTY OF THE PR A PROPERTY OF THE PARTY OF THE TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fround relative defluing the standard properties. The attention of the standard properties and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND) / DEPARTM			MENTAL HYGIEN		
	1. DECEOENT'S NAME (First, Middle, Last) Baby Riley					2. DATE OF DEATH MONTH MAY 1,	"1995 ^{YEA}	2. TIME OF DEATH 19:48 p M
	NOTIC	M 2 🔀 F	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) May 1,	Co	RTHPLACE (State or Foreign untry) MARYLAND
TOR	96. FACILITY NAME (If not institution, give street ar Montgomery Gener RESIDENCE OF DECEDENT			Oln	R LOCATION OF DE	ATN	9c. COUNTY O	F DEATH GOMERY
DIRECTOR	Maryland Monto	jomery		www or Locat	Spring			10d. INSIDE CITY LIMITS? 1 YES & NO
FUNERAL	3506 Peartree Co			101.	20906		7	S.A.
B	1 C Never Married 2 Married F	WAS DECEDENT EVER IN U.S. ORCES? 1 TYPES 2 TYPES, GIVE WAR OR DATES		If yes, spe	ENDENT OF NISPANI city Cuban, Mexican 2 NO Specify:	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	В	ACE - American Indian, lack, White, atc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete (Specify only highest grade complete (Specify Only) (C-12) Coll None	t 18e. eted) 18e. ege (1-4 or 5 +)	DECEDENT'S USU. (Give kind of work of life. Do NOT use reti	done during mos red.)		166. KIND OF BUS		Y
BE COM	17. FATNER'S NAME (First, Middle, Last) Jerome Jackson		I VOI			ME (First, Middle, Maiden ette MCMa	Surname)	
2	Jerome Jackson		3506 P	eartr	ee Ct.,		llver S	Spring, MD
	20a, METNOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify) 21. BICMATINE OF FUNERAL SERVICE LICENSES	Gate	CEAND DATE OF DIS	även		5/8 Si	Lver S	oring, MD
	23. PART i. Enter the diseases, or compli	Duon	Lly	SNOW	DEN FUN	NERAL HON	50	
	ahock, or heart feiture. List o IMMEDIATE CAUSE (Ringl disease or condition resulting in death)	Respiration as a con	ine.	/		4		Approximate Interval Between Onset and Death
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON				,		
CERT	resulting in death) LAST							
MEDICAL	PART ii. Other eignificent conditione con	ributing to deeth but no	ot reaulting in th	e underlying	ceuse given in F	Part i. 24a, WAS AN PERFOR	MEO?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: M	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. Pt	EATH YES [UNCERTAIN			1 TES 2 NO
PHYSIC	1 TYES 2 NO IT	SPITAL: Inputient 2 ER/Outputient 28e. DATE OF INJURY		HER: Nursing Nome 28c, INJU	5 Residence S	B Other (Specify) 26d. DESCRIBE HOW II	JURY OCCURED	
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28s. PLACE OF INJURY — At building, atc. (Specify)	INJURY home, ferm, atreet	M 1 V	ES 2 NO	281. LOCATION (Street a		
PLETED	4 Homicide determined 29e. CERTIFIER (Check only)		death occurred at	Ihe time, data	and place, and due t	City or Town, State)	Der de stated.	
COMPLE	2 MEDICAL EXAMINER: On to					lime, data and place, and	due to the caus	e(a) and manner as stated. (a) (Mopth, Day, Year)
IO BE	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (I	TEM 27) (Type, Print)		D320	03	▶ 5/	1/95
	. 0	A MD.		PRI	NCE PI	HILLIP D	ROLI	154 MD 20832
	MAY 08 1995 9	whi drucker Re	rdall					



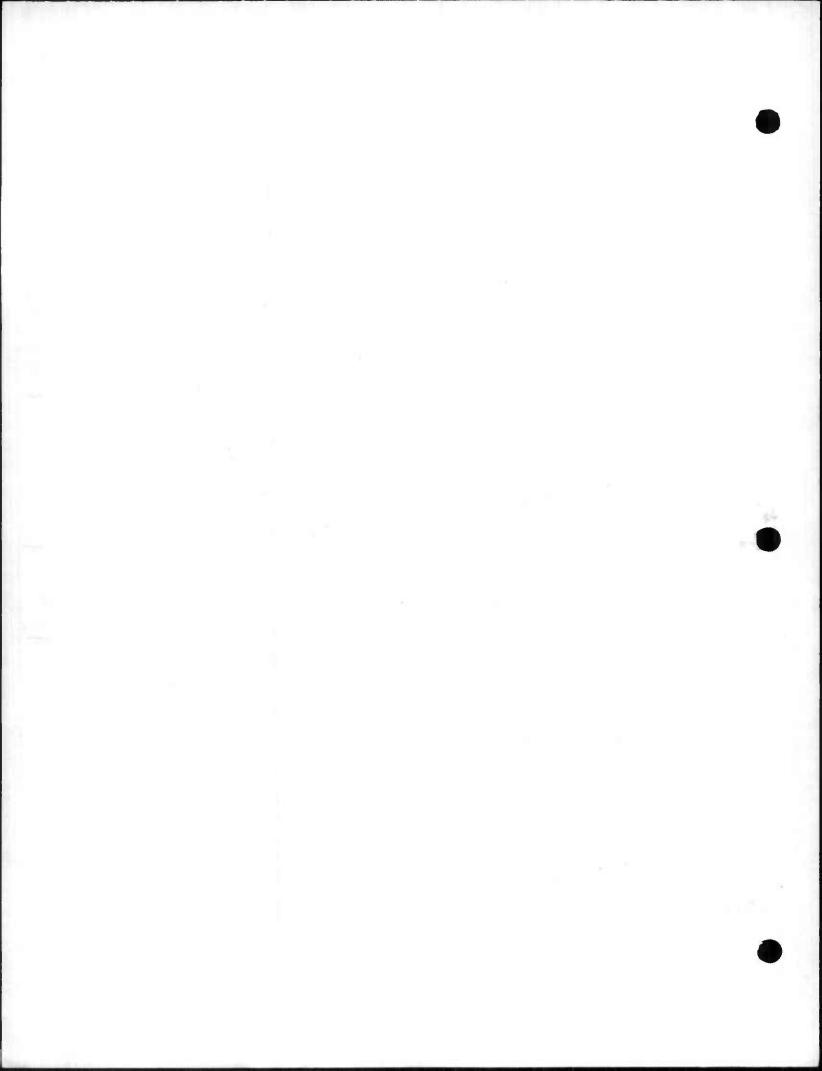
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Leat)

2. DATE OF DEATH

2. DATE OF DEATH

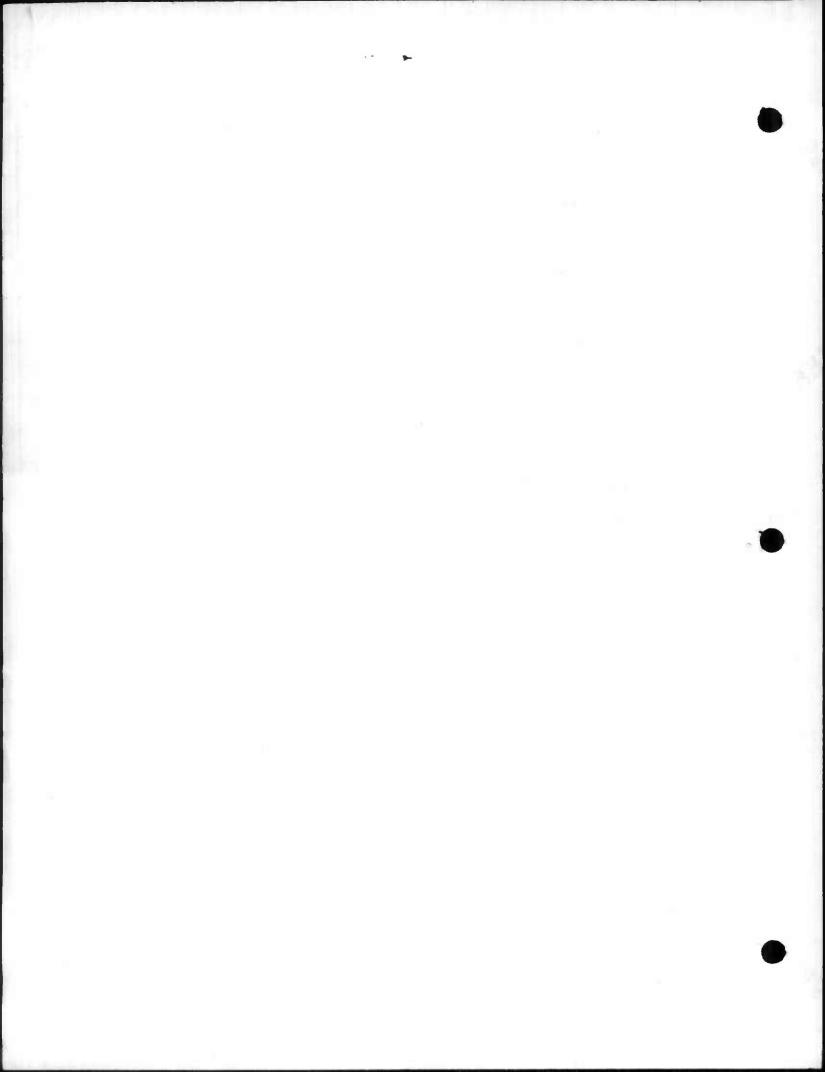
			1. DECEDENT'S NAME (First						0/11/2	. 01	DEA		2. DATE	OF DEATH	DAY	YEAR	3. TIME OF DEATN
			JOHN HERBE 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SOCIAL SECURITY NUMBER 6. SOCIAL		ES 5. SEX	8 AGE //r	n yrs. faal b	hirtholms)	IF UNDER	1 7540					1995		0235 A M
	- 1		577-28-8621		1 DM 2 DF		rr yra. raan s	-	MONTHS	DAYS	HOURS	MIN.		OF BIFITH h, Day, Year)		Country)	
should			9a. FACILITY NAME (If not is	natitution, give a	A	75		10071	9b. CITY.	TOWN (OR LOCATI			uary		lashi	ngton, D.C.
2, 3 sh		СТОВ	Montgomery	Genera		al				01n						tgom	
2		LU I	RESIDENCE OF DE	10b. COUNT	7			10c. CITY,	TOWN O	R LOCAT	TION						Od, INSIDE CITY
Pages		DIA	Maryland	м	ontgomer	177				neat							LIMITS?
permit.			10e. STREET AND NUMBER		OHEGOMET	у			VVI		ZIP COD	E			10g. CITIZ		AT COUNTRY?
TS.		H	3709 Kayson	Stree	t						209	06				U.S.	Δ
020 physician. burial-transit		FUNERAL	11. MARITAL STATUS		12. WAS DECEDED	NT EVER IN	U.S. ARME	ED	13. \	MAS DEC	ENDENT (OF HISPAN	IIC ORIGII	N? (Specify Y		14. RACE -	- American Indian, White, etc.
		ВУ	1 Never Married 2 😾		IF YES, GIVE						2 X NO			Rican, etc.)		Specify:	
215-0 attending se as the		0	15. DEC	EDENT'S EDU	CATION		16a. DECE	EDENT'S I	ISHAL OC	Y IDATI	DN	<u> </u>	1 40	VIND OF D	USINESS/INDL	Whit	e
212			(Specify on Elementary/Secondary (I	y highest grade	completed) College (1-4 or 5		(Give	kind of wo	ork done d	luring mo	isi of worki	ng	100	K KIND OF B	USINESS/INUC	JSTRT	
ND hospital			12	-12,	College (1-4 or 5		Mast	er C	larne	ente	r		C	arpen	tra		
AND 21 the hospital or detached for u	once	COMPL	17. FATHER'S NAME (First, N	fiddle, Last)								HER'S NA		Middle, Maide			
2 8 4	16	BE (Raymond R.								He	nrie	tta	M. Fr	ench		
MAR retained 5 should	notified	0	19a. INFORMANT'S NAME (19b. I	MAILING /	ADDRESS	(Street a					wn, State, Zip (Code)	
- 3 8	pe n		Evelyn M. J				37	09 K	Cayso	on S	tree	t W	heat	on, M	arylan	d 20	906
6 may	must		20a. METHOD OF DISPOSIT 1 Burlel 2 K Crematic	on 3 🗆 Rem	oval from State	came	PLACE AN stary, crema	stone or oth	ne olecel				DAT		OCATION — C		
Page 6	120		4 Donation 6 Other		meter	7 Me	trop	olit	an (Crem	ator	y 5	/11/	95 A1	exandr	ia,V	irginia
	caminer	1	1//	//	11	M.	00							s Fun	eral H	ome.	Inc.
BAL after death	. 6		Mar	12-6	. //4	eee	Elle,		50	00 11	nive	rsit	v R1	W. by	Sil	Spr	,MD 20901
ANY SE	medical		23. PART I Enter the d shock, or h	iseasea, or c aart fallure.	complications the	nt caused use on eac	the deat	th. Do no	ot anter	tha mo	de of dy	ing, auci	h as can	diac or rea	piretory arre	at,	Approximate Interval Between
filled ho			IMMEDIATE CAUSE (Fir		,	,	0 -	-1.		1	2/		0				Onset and Death
fetely in	nt, ti		disease or condition	→	Gast					(20	2	*				3-4 DAYS
somp comp	E eve	_			A SOE TO	(OR AS A	CONSEQU	ENCE OF)):	`							YFARE
executed and con	ror to burn traumatic	ō l	Sequentially list condit if any, leading to imme		DUE TO	(OR AS A	CONSEGU	ENCE OF)	10								12.11-8
rie be	trae	PA	cause. Enter UNDERLY	ING	Hey	nat	t	7									YEARS
certificate ding physi	other	CERTIFICATION	CAUSE (Disease or injuthat initiated events		DUETO	(OR AS A	CONSEQU	ENOE DF)	N.	/	0		مره				YEARS YEARS 8 Mouths
7 - 6-	y, or	FR	resulting in death) LAS		1/ex	hte	i	2m	ICC	pole	lop	24	X				8 Milling
Se e	E 2		PART II. Other algnifice	nt condition	a contributing to	deeth bu	it not rea	uiting In	the un	derlying	ceuse	given in	Plant I.	24a, WAS A	N AUTOPSY	24b. W	PERE AUTOPSY FINDINGS
7 5 74	- B	IEDICAL			- 2										PAMED?	A	WAILABLE PRIOR TO OMPLETION OF CAUSE
	W Hear										/		_	1 TYES	2 (1)40		F DEATH?
- 0.	23 sh	ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH	H YES	1 0	10 E	UNC	ERTAIN	10				_ 120 2 _ 110
The law	Item 2	SICIAN:	25. WAS CASE REFERRED T	O MEDICAL	HOSPITAL:	2	6. PLACE	-									
SICIAN: The Certificate	or it	YSi	1 TES 2 NO		1 D Inpetient 2	☐ ER/Outpat	itlant 3 🗆		OTHER		• 5 🗆 Re	sidence	6 Othe	r (Specify)			- 1151
OR ATENDING PHYSICIAN: The DIRECTOR: After this certificate in the cer		PHY	27. MANNEY OF DEATH 1 Netural 5	Pending	28a. DATE OF (Month, E	Ony, Year)	1	28b. TIME INJU	RY	28c. INJ WO	URY AT		28d. DES	CRIBE NOW	INJURY OCCU	JRED	
After B	H S	B≼	2 Accident	investigation	An - 84 AGE 6	and the state of			М		/ES 2 [NO					
TENO TENO	9 00	0		Could not be determined	28a. PLACE C building.	etc. (Specif	— At home (y)	o, farm, str	reet, facto	rry, offici				ATION (Street or Town, State	and Number o	r Rural Rou	te Number,
OR ATTENDING DIRECTOR: After	E	5	29a. CERTIFIER														
	7 =	COMPL	(Check only		CIAN: To the best of												
THE HOSPITAL THE FUNERAL	PORTANT:	8				Xarrination :	allozof ille	estigation,	, in my op	anion, d				and place, a			nd manner as stated.
물물	2 3	BE	296. SIGNATURE AND TITLE	-1	9	M	D				29c. LICE	() //	BER)	29d. DATE	SIGNED (Y	Day, Year)
2 2 2	8 🗷	2	30. NAME AND ADDRESS OF	- () !		SE OF DEAT	TH (ITEM 1	27) (Time #	Print!		117	57	20		1-7	110/	0
121	-10		18/11 PR	NCE	PHICE	-	1:			C	DIM	9	-	47	208	32	
	9		31. DATE FILEO (Month, Day,		32. REGISTRA							0	-				
	L		MAY	12 199	5 Steller d	Thousa	molan	tall									



1 - FOR STATE REGISTRAR

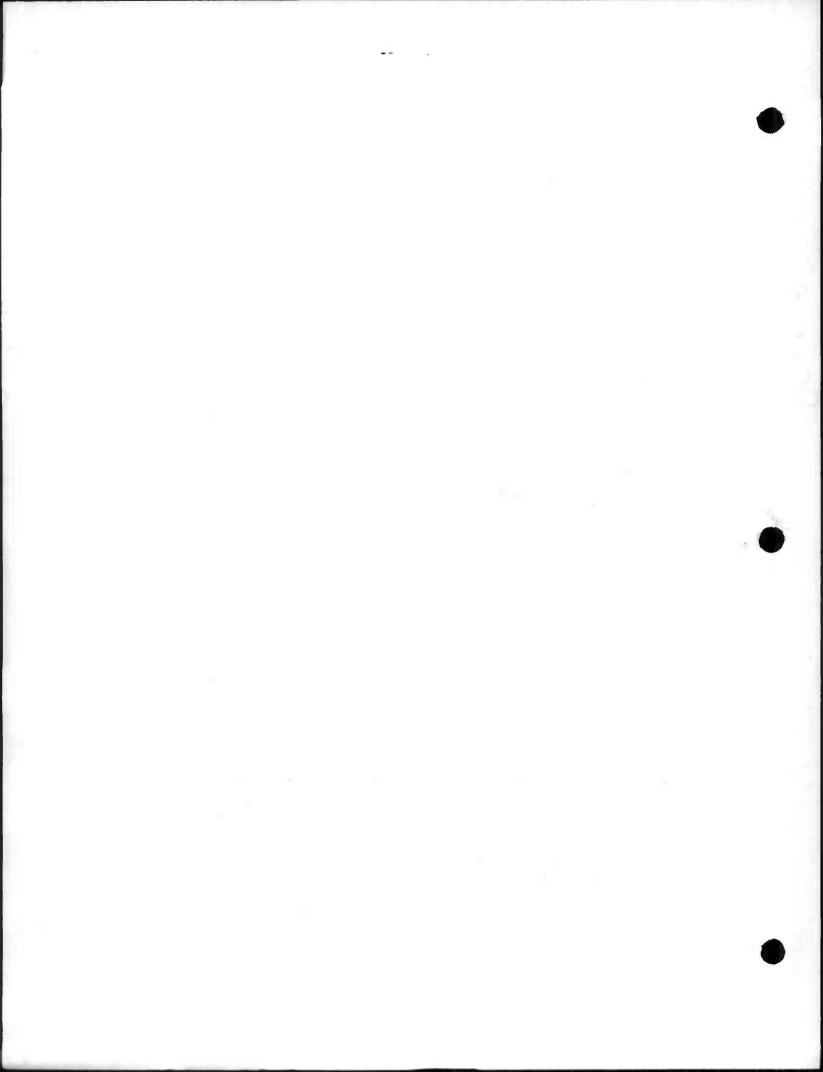
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		4 DESCRIPTION NAME OF TAXABLE			OL.	HIOA	I L O	DEA		REG. NO			1
		1. DECEDENT'S NAME (First, Middle, Las.								2. DATE OF DEATH	AX.	YEAR 3. TIME OF DEA	HTH
			118 1	OHN			r.			MAY.	8 . 19	195 54	9 M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. lest birti		DER 1 YEAR			7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or !	Foreign
10		219-10-1469	1 M 2 F	82	Y	RS. MONTH	DAYS	HOURS	MIN.	June 22,	1911	Maryland	
Should		9e. FACILITY NAME (If not institution, give	atreet and number)			9b. C	ITY, TOWN	OR LOCATI	ON OF DE		7	Y OF DEATH	-
6	5	SOUTHERN MY	Anylowo ?	4000	17701		0	KINT	~ \		D.	INCK- GET	- /-
1, 2,	CTOR	RESIDENCE OF DECEDENT	riginio i	1037	MAL			NINI	6N		/ ^	INCK- OCT	areas
Pages	DIRE	10a. STATE 10b. COUN	TY		10-	c. CITY, TOW	N OR LOC	ATION				10d. INSIDE CIT	Y
ئے۔	0	Maryland Pri	nce Geor	ge		Clin	ton					LIMITS?	NO
permit.	AL	10e. STREET AND NUMBER						10f. ZIP COD	E		10g. CITIZI	N OF WHAT COUNTRY?	
15	FUNERAL	11810 Thirft	Rd					2073	2.5				200
020 physician. burlal-transit	S	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN	U.S. ARMED		3 WAS D			IIC ORIGIN? (Specify Yea	or No. 4	U.S.A 4. RACE — American Ind	
UUZUU ng physik ne burial	4	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES	2 NO		If yes,	specify Cubs	n, Mexica	n, Puerto Rican, atc.)		Black, White, etc.	1011,
nding as the	B	3 ₩Idowed 4 □ Divorced	1 125, 0172 1	on on	1120		1 🗆 🔻	ES 2 F NO	Specin	γ:		Specify: Black	
- w	G	15. DECEDENT'S ED			16e. DECEDE					16b. KIND OF BUS	SINESS/INDU		
Z1Z al or att for use		(Specify only highest green (S	College (1-4 or 5 +	,	(Give kii life. Do f	nd of work do IOT use retire	ne during r d.)	most of worldi	ng	ATTACK CONT.			
ND hospital ached 5	립	12	0011090 (1-4 01 0 1	']	Skil	led	Laho	ar .		Park &	Dlar	ning	
the hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)	-		DATI	100	Парк		HER'S NA	ME (First, Middle, Meiden		ming	
2 8 8 E	- 1	Willie Johnso	an .										
should should	BE	19a. INFORMANT'S NAME (Type/Print)	311		10h MA	II INC ADDD	ECC /Com o			ttia Smi			
> = 10	임	Pearline Johns	7.00										
E Sage		20a. METHOD OF DISPOSITION	SOII						I,CI	inton MD			
octor, p		1 □ Suriel 2 □ Cremetion 3 □ Re	moval from State	20b.	PLACE AND E	ATE OF DISP y or other pla	OSITION (Name of	_	OATE 20c. LO	CATION — CI	ty or Town, State	
	10.0	4 Donation 5 Other (Specify)	PERSONAL PROPERTY.	UI	nion	Beth	el A	A.M.E	5	/11/95 B	randy	wine Md	
death. Pag tuneral di funeral di examiner		21. SIGNATURE OF TURESTAL SERVICE C	000			1	2. NAME	ANO ADDRE	SS OF FA	CILITY			
BAL ter deal the fun aval.		Land	Cola				Adan	ns Fu	ner	al Home,	Δαιιας	CO MD 20	608
hours after the in by the or removal medical		23. PART i. Enter the diseases, or	complications that	t coused	the deeth.	Do not en	er tha m	node of dy	ng, suci	h as cardiac or respi	ratory arms	it, Approxim	
B 5 .5 B		allocate or liears selling	. List only one cau	se on se	ch ilne.			0				Interval 6	Between
Pe Pe		iMMEDIATE CAUSE (Final disease or condition	1.1.	1.		1.0	/	10				Onset an	d Death
rted within 24" completely fille fal, cremation,		resulting in death)	a	USU	CONSEQUEN	you	4	rey	mo	wa_		In	n
\$ 2 5	_		1//	6/	CONSCOUEN	1	/	2/.				1,1	
be executed sictan and con rior to burial, traumatic en	8	Sequentially list conditions,	b. DUE TO	(OF AS A	CONSEQUEN	7-1-	1	XI	w	7		14	n
ysician prior to	\{	if any, leading to immediate cause. Enter UNDERLYING	Δ.	0 11	L	CE 017:				0		1211	_
ertificate be ing physician giene prior to	[윤]	CAUSE (Disease or injury	C. DUE TO	7 1	CONSEQUEN	et op	+ /-					201	
	∰	that initiated events resulting in death) LAST		nai	MI (C)		14 .4		,	2. 11	/	, 24	1/2
te death certil the attending Mental Hygien Ijury, or oth	CERTIFICATION		dU	141	mu	, W	ren	ma	17	Jum Sc	ud	us 61	12
E Me e		PART II. Other aignificent condition	ons contributing to	deeth bu	t not reaul	ing in the	underlyi	ng cause (given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY I	PINDINGS
	DICAL									PERFOR		AVAILABLE PRIOR	OT F
signed Health and was am	<u>B</u>									1 TYES 2	NO	OF DEATH?	10.00
law requast been of 1	Σ	DID TOBACCO USE CON	TDIRLITE TO CA	LICE OF	E DEATH	VEC [NO.		EDTAIN			1 YES 2	NO
m 25 W	ICIAN:	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA		26. PLACE OF				EKIAI	4 L			
N: The scate his State D	흥	EXAMINER?	HOSPITAL:			ОТН		"/					
PHYSICIAN: this certifica with the St riked, or it	IYS	1 YES 2 NO 27. MANNER OF DEATH	1) Inpatient 2				_		eldence	6 Other (Specify)			
NG PHYS fler this ceath with marked,	PH	1 Natural 5 Pending	28e. DATE OF (Month, Di		286	TIME OF	W	NJURY AT		26d. DEŞCRIBE HOW II	NJURY OCCU	RED	
	ΒY	2 Accident Investigation				М		YES 2] NO				
ATTENDING ECTOR: After s after death	8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY - atc. (Speci	— At home, fi	irm, street, f	actory, off	Ica		281. LOCATION (Street e City or Town, State)	and Number or	Rural Route Number,	
DR ATTENDING DIRECTOR: After hours after death tem 28 is ma	H	4 Homeloe determined											
	7	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of	my knowle	edge, death o	corred at th	e time, da	te and place.	and due	to the cause(a) and man	ner as stated		
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COMPLE											cause(a) and manner as :	stated.
TO THE HOSPI TO THE FUNER De filed within		29 SIGNATURE AND TULE OF CERTIFI				4 4 5		_	NSE NUN			1	
F 등 등	8	12	1. 1	103	5 1	DA	- 1	Tar Tick	אטא זפיי.	150-2	29d. DATE S	GIGNED (Month, Oby, Year)	4
2 2 3 3	유	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	E DE DE	TH OTEN OF	Kh.	dr	+ 1)	- 6	7227		11195	
		1.4	4	T.	Orn (FEM 27)	A		14	1	0	/ -	20	1737
İ		31 DATE FILED (Month Day Mar)		100	UNI	15/	1. ANG	-11 7	TVE	NUE CA	INTOI	MANAMIN	W
		31. DATE FILED (MONTH Day, Year) MAY 1 2 199	32. REGISTRA	Ab and	LOT RON	1 11							
		- L L 100	Junas	~ may	AND A LAND	all y							



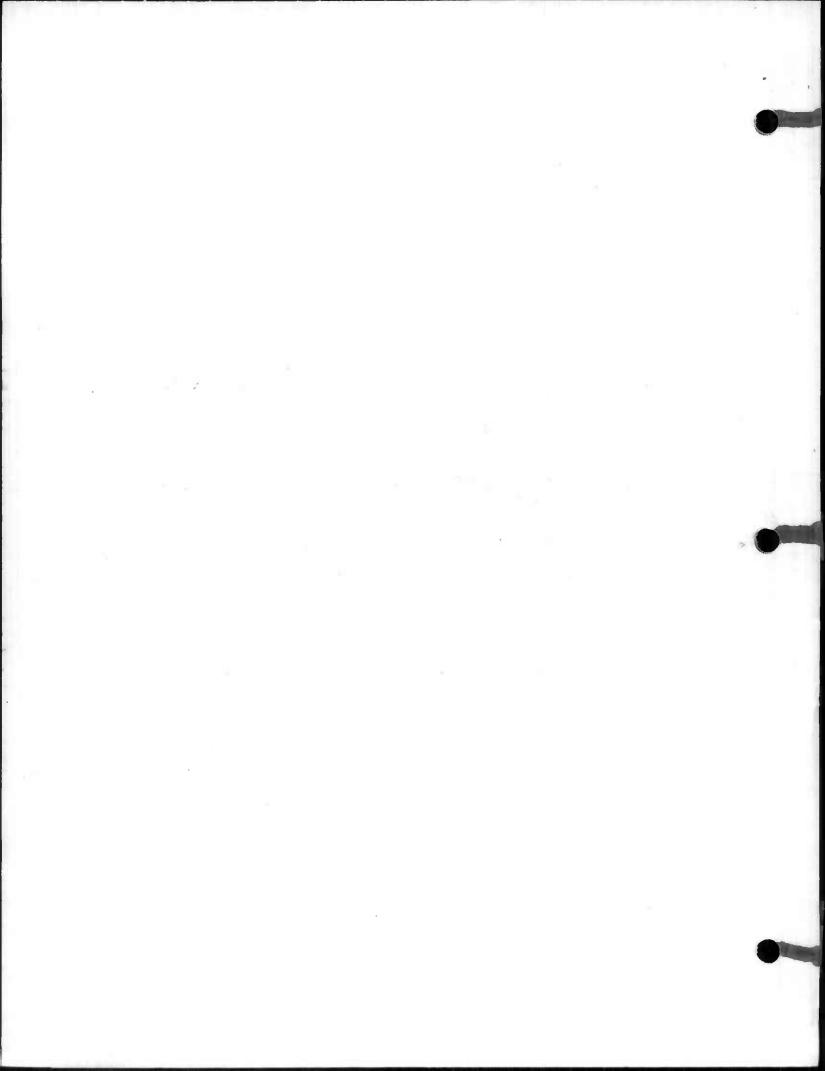
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MENT	TAL HYGIEN			
1	1. DECEDENT'S NAME (First, Middle, Last)								TE OF DEATH			3. TIME OF DEATH
	MARVIN J.	JONES,	SR.					MA	ү 9 Ү 9	, 19	995	м
	4. SOCIAL SECURITY NUMBER		S. AGE (In yrs. Is	st birthday)	IF UNDER		IF UNDER 24 HRS.	7. DA	TE OF BIRTH	,	8. BIRTNI	PLACE (State or Foreign
	213-40-5182	1 € M 2 □ F	53	YRS.	MONTHS	DAYS	HOURS MIN.		onth, Day, Year)	941	Was	nington DO
NC.	98. FACILITY NAME (If not institution, give a PRINCE GEORGES	GENERA		PITAI		EVE	RLY		50.57	9c. COU	INTY OF DE	
5	RESIDENCE OF DECEDENT									_		
DIRECTOR	10a. STATE 10b. COUNT	-			Y, TOWN C							10d. INSIDE CITY LIMITS?
	Maryland Char	les		Hu	ighe	svi	lle					1 X YES 2 NO
PAI	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	P.O Box 207						20637			U.	S.A	
F	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1					ENDENT OF HISPA			or No-	14. RACE Black,	— American Indian, White, etc.
8	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				2 NO Speci		, , , , , , , , , , , , , , , , , , , ,		Specify	
	15. DECEDENT'S EDU	CATION	16a. D	ECEDENT'S	USUAL O	CHIPATIC	NA .		I6b. KIND OF BU	CINECC III	OLIGANA	Black
E	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(1)	Bive kind of a	work done i	during mo	st of working	- 1	IOD. KIND OF BU	SINE SS/INI	DUSTRY	
7	1 2	College (1-4 or 5+)	Hea	vy E	ani	nme	nt	1	Constr	nct i	or	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1.100		- qui	Pane	16. MOTNER'S N				. 011	
	David Jones								verstz			
) BE	19a. INFORMANT'S NAME (Type/Print)		16	b. MAILING	ADDRESS	(Street a	nd Number or Rural			n, State, Zio	o Code)	
5	Yvette Jones						ale Dr.				,	3.5
	20a, METHOD OF DISPOSITION		20b. PLACE			-					City or Tow	
	1 № Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Resu			n	Cem. 5/	1				
1	21. SIGNATURE OF PUNERAL SERVICE LI	CENSEE	TROBO	ILLCC	-		D ADDRESS OF F		73 61	TILLC	711 141)
	De Thomas	60			Δ.	dam	s Funer	ra l	Home	λαιιο	500	MD 20608
CERTIFICATION	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (C	PR AS A CONSE	OUENCE OF	F): F):	3						Interval Between Onset and Death
PHYSICIAN: MEDICAL C	PART II. Other significant condition				in the un			_	24s. WAS AN PERFOR 1 YES 2	IMED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\subseteq \) NO
ट्	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEAT	N (Check of							
YS	1 X YES 2 NO	1 ☐ Inpatient 2 X			4 🗆 Nurs	ing Hom	5 - Residence	6 🗆 Ot	her (Specify)			
H	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF III	IJURY Year)	28b. TIM	URY		RK7	28d. D	ESCRIBE HOW I	NJURY OC	CURED	
B	2 Accident investigation	5/8/95		1 0	PM	1 🗌 Y		FE	il off	TRY	EE	
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF building, et	injury — At he c. (Specify)		rireet, facto	ory, office		D C	ocation (Street a ity or Town, State)	MG F	or Rural Ro	IGHVILLE
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYS 2XXMEDICAL EXAMINE	CIAN: To the best of m										and manner as stated.
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2	MARIO GOLIES	O COMPLETED CUSE	111	Pen		ree	et, Bal	tim	ore, N	Mary	land	21201
	31. DATE FILED (MOORD, Day, Year) 1995	32. ANGISTRAR	s signature Lucker	ardall								



BALIIMORE, MARYLANI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with mounts after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	OR	DIA JOUR	Hen
	TAL	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	=
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Lest) WALTOR Ea:	223L 11	Jr.			2. DATE OF DEATH DO MAY 9	YE. 199	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.8	HRTHPLACE (State or Foreign
	217-84-8713 Be. FACILITY NAME (If not institution, give s	1 M 2 F	34 YRS.	MONTHS DAYS	OR LOCATION OF D	4	1061	Maryland
Œ	Seton Hill Man				timore	EATH		
6	RESIDENCE OF DECEDENT			Dal	cimore		<u>Ci</u>	ty
DIRECTOR	10a. STATE 10b. COUNTY	Y		TY, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
	Maryland		Ba	altimor				1 X YES 2 NO
FUNERAL	10s. STREET AND NUMBER	- 1		10	f. ZIP CODE			OF WHAT COUNTRY?
NE I	909 Washingto	n BLVC. 12. WAS DECEDENT EVER IN			21230			S.A.
	1 Never Married 2 Married	FORCES? 1 VES	2 NO	If yes, s	ecify Cuben, Mexic	NIC ORIGIN? (Specify Yes en, Puerto Rican, etc.)		RACE — American Indien, Black, White, etc.
В	3 Widowed 4 Divorced		1982	1 U YE	3 2 NO Speci	fy:		Specify:White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPAT	ON of worklass	16b. KIND OF BUS	SINESS/INDUST	RY
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 8+)	life. Do NOT u	work done during m ise retired.)	ost of working			
₽	12		0pt	tician			ealth	
	17. FATHER'S NAME (First, Middle, Lest) Walter Earl J	occ Sr				AME (First, Middle, Melden		
BE	190. INFORMANT'S NAME (Type/Print)	ess si.	405 44411 1114			ra Witemo		
임	Guy Fletcher					Oakton,		
	20a. METHOD OF DISPOSITION	20h		OF DISPOSITION (A			CATION — City	
	1 Surial 2 Cremation 3 Remarks Donation 5 Other (Specify)	oval from State cem	etery, crematory or o	other place)				
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	vergre	22. NAME A	ND ADDRESS OF F	S D/ TZ T T	The Elect	eral Home
	Many I.	Lekher		254	E. Main	St. West	tminst	er, Md
	iMMEDIATE CAUSE (Final disease or condition	List Dnly one cause on a	nch lina.			ch aa cerdiac or reapi	retory arrest,	interval Between Onset and Death
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE O	PE:	4.1			5yrs.
z		. ADVANC	20 K	HV IN	FECTION	}		į
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):				
	CAUSE (Disease Dr Injury	C. DUE TO (OR AS A	CONSEQUENCE O					
<u>E</u>	that initiated events resulting in death) LAST	DOE TO (ON AS A	CONSEGUENCE O	7,				İ
핑		d						
A	PART II. Other algolificant condition			In the underlying	g ceuse given in	Part i. 24s. WAS AN PERFOR	AUTOPSY IMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	PERI-AND	is CASTACIL	17			1 YES 2	246	COMPLETION OF CAUSE OF DEATH?
E	DID TOTAL CO. 1107						^	1 TES 2 THO
PHYSICIAN:	DID TOBACCO USE CONTI				UNCERTAI	N 🗆		
S S	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 00	HOSPITAL:		TH (Check only one				
ξ	27. MANNER OF BEATH	1 Inpatient 2 ER/Outp	etlent 3 [] DOA 28b. Tife		DURY AT	8 Other (Specify) 28d. DESCRIBE HOW II	u num aaaun	
	Natural 5 Pending	(Month, Day, Year)	IN.	JURY W	YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURE	D
BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, ferm,			281, LOCATION (Street of	and Number or Ro	ural Route Number
茰	4 Homicide determined	building, etc. (Spec	Hy)			City or Town, Stete)		,
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my knowl	edge, death occum	red at the time dat	end place, and du	to the causalat and man	mer se stated	
M		R: On the beele of examination						use(e) and manner as stated.
ВСС	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			NED (Month, Day, Year)
8	CHANL	Mo			D3977	11		10.95
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	, Print)				
	David MHECTS	R 29 50	out or	56670	ST P	m 226 B	JUMA	ed mo
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNA	ATURE		· · · · · · · · · · · · · · · · · · ·			
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 ma	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

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31. DATE FILED (Month, Day, Year)

MAY 1 5 1995

38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

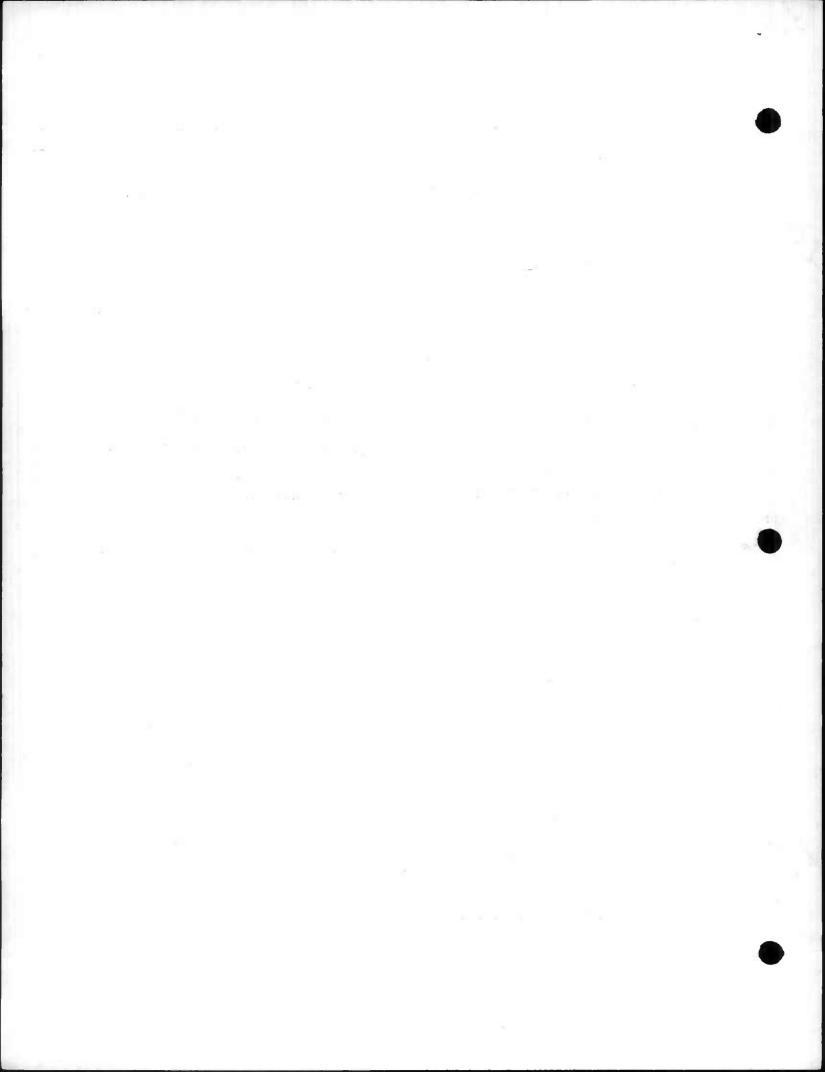
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN HELEN MAY. **JENKINS** 1995 01:30 AM M 11st 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH HOURS 1 M 2 X F 263 - 07 - 5677 July 11, 1908 New York Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUNTY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Millersville 1 TES 2 NO permit. FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? lage 5 should be detached for use as the burial-transit 309 Beech Grove Court 21108 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Nurse Hospital 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) John Beyer 7 Christine Pfeil BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Jenkins 309 Beech Grove Ct. Millersville, Maryland 20707 9 20e. METHOD OF DISPOSITION
1 ☐ Burlef 2 ☐ Cremetion 3 ☒ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION - City or Town, State must "Maplewood" Cemetery 5/13 Saratoga Springs, N.Y. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE-OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 medical 23. PART I. Enter the disease shock, or heart to of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Interval Between 9 Onset and Death IMMEDIATE CAUSE (Final the disease or condition Acute Acte his cardial to furction
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) shows any injury, or other traumatic event, Health and Mental Hygiene prior to burial, Coronau CERTIFICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL terstitul Echnocii 1 YES 2 NO OF DEATH? 1 YES 2 NO 8 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Пеш State HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO 4 Nursing Nome 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with marked, 1 Natural 5 Pending M 1 YES 2 NO BY death 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 40 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be after 4 Homicide 200 hours 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 TO IMPORTANT: If IN (Check only one) 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as atsted. 29b. SIGNATURE AND TITLE OF CERTIFIER

> DAVID A. SCHWARTZ, M.D./300 HOSPITAL DRIVE, #215/GLEN BURNIE, MARYLAND 21061 32 REGISTRAR'S SIGNATURE Falia Develor Radall

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

1/11/95



permit. Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. ours after death. Page 6 may be

BALTIMORE, MARYLAND 21215-0020

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32. REGISTRAR'S SIGNATURE

attending physician and completely filled in by the mtal Hygiene prior to burial, cremation, or removal.

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After death

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FUNERAL DIRECT within 72 hours a TANT: If Item 2

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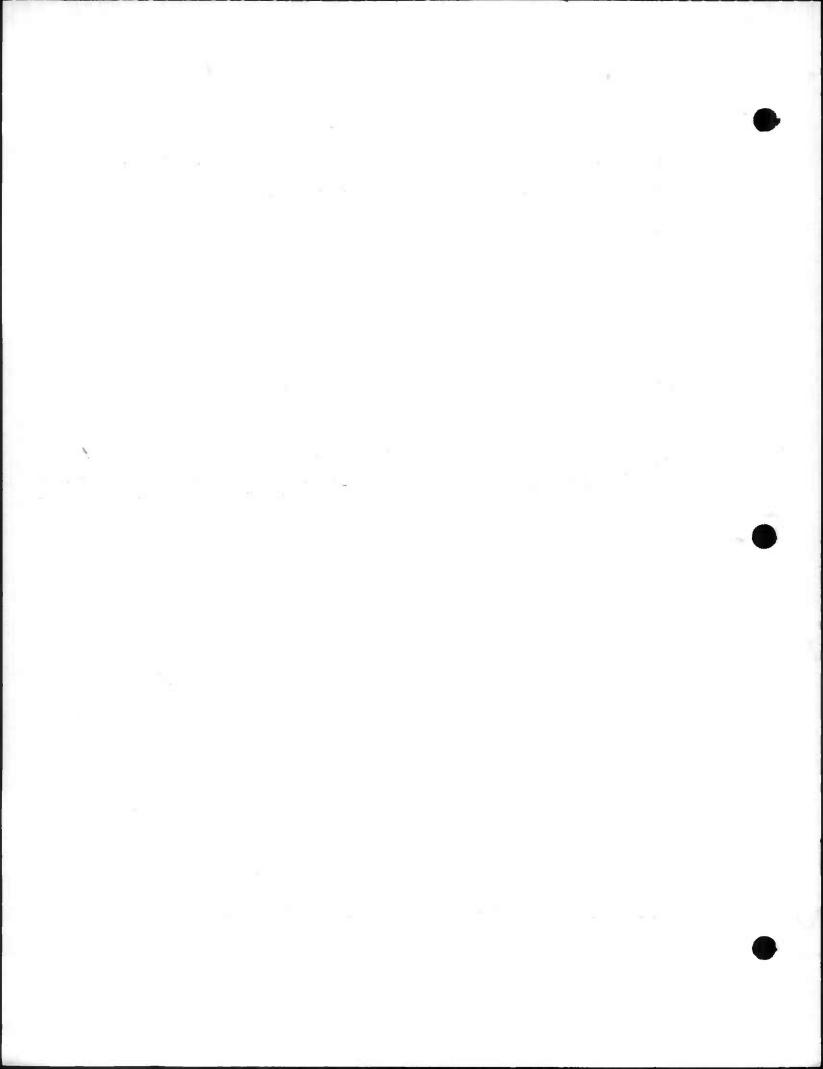
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marked,

DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN: The law

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OFATH 3. TIME OF DEATH YEAR K LINDA JOHNSON MAY 10 1995 08:30 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) S. BIRTHPLACE (State or Foreign DAYS 1 M 2 X F FEB 21 1946 219-44-0744 MARYLAND 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 425 CENTRAL AVE. ALLEGANY CUMBERLAND, MD. RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY LONACONING 1X YES 2 NO 10e. STREET AND NUMBER 101 710 CODE 10g. CITIZEN OF WHAT COUNTRY? 3 PLEASANT STREET 21539 USA 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yea, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 X Never Merried 2 Married Specify: WHITE 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grede Elementary/Secondary (0-12) College (1-4 or 5+) FIBER/TEXTILE 12 SPINNER 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) JOHN R. JOHNSON EMMA JEAN WALTERS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) APRIL 3 PLEASANT STREET LONACONING, MD 21539 **JOHNSON** 20e. METHOD OF DISPOSITION
1 Burlei 2 Cremation 3 Removal Irom State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE SILBAUGH CREMATORY 4 Donetion 5 Other (Specify) 5/16 UNIONTOWN. M PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE. MD 21502 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or haart failure. List only one cause on each line. intarvai Between IMMEDIATE CAUSE (Final Onset and Daath Myocardial Infarction resulting in death) One Hour DUE TO (OR AS A CONSEQUENCE OF): Coronary Atherosclerotic Disease 6 Years Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate CAUSE Enter UNDERLYING Atherosclerosis 10 Years CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST Hypertension 20 Years PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MAIL ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 N Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO investigation 2 Accident 26e. PLACE OF INJURY — At home, larm, streat, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(e) end manner ee stated. 2 MEDICAL EXAMINER: On the beele of axamination end/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 16150 MAY 11, 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SETON DRIVE CUMBERLAND, MD 21502 FADL 921



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TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTS be filed within 72 hours at IMPORTANT: If Item 2

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1 YES 2 NO

5 Pending

29b. SIGNATURE AND TITLE OF CENTREE

Investigation

6 Could not be

27. MANNER OF DEATH

Ica Hatural

2 Accident

3 Sulcide

4 Nomicide

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Pages 1, 2, 3 should

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN May 1995 Charles Franklin King 6:50 PM 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs last hirthday) 7. DATE OF BIRTH
May 14, 1922 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS Maryland 219-20-2284 1 XXM 2 - F 73 9e. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH COUNTY OF DEATH Frederick Frederick Memorial Hospital Frederick DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Frederick Maryland Frederick 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 5730 Jefferson Pike 21702 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 XX Never Married 2 Merried IF YES, GIVE WAR OR DATES WW II BY Spec#yWhite 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Plant Operator City Water Plant 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) Lillie Grace Rice Charles King BE 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code, 2 5730 Jefferson Pike, Frederick, Md. 21702 Mrs. Eleonora M. Easterday 20a, METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Buriel 2 Cremation 3 Removal from State St. Pauls Lutheran Cemetery May 17, 1995 Jefferson, Md. 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home M00255 106 East Church St., Frederick, Md. 21701 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or raepiratory arrest, shock, or heert feilure. List only one gause on each line. Approximate intervai Between **Onset and Death IMMEDIATE CAUSE (Finei** disease or condition resulting in death) 0 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in deeth) LAST PART II. Other significent conditione contributing to deeth but not recuiting in the underlying ceuee given in Part i. 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO

O DILATOD CARDIOMY OPATITY 3 AULTI-IN FARCT DOMON @ POURROM OSTEDAYEZITIS @HIP DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?**

TO YES 2 MANO COMPLETION OF CAUSE 1 | YES 2 | NO

29d. DATE SIGNED (Month, Day, Year)

15

OTHER 15 Inpatient 2 - ER/Outpetient 3 - DOA

4 Nursing Home 5 Residence 6 Other (Specify) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify)

29c. LICENSE NUMBER

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es attend.

ation end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner as stated.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

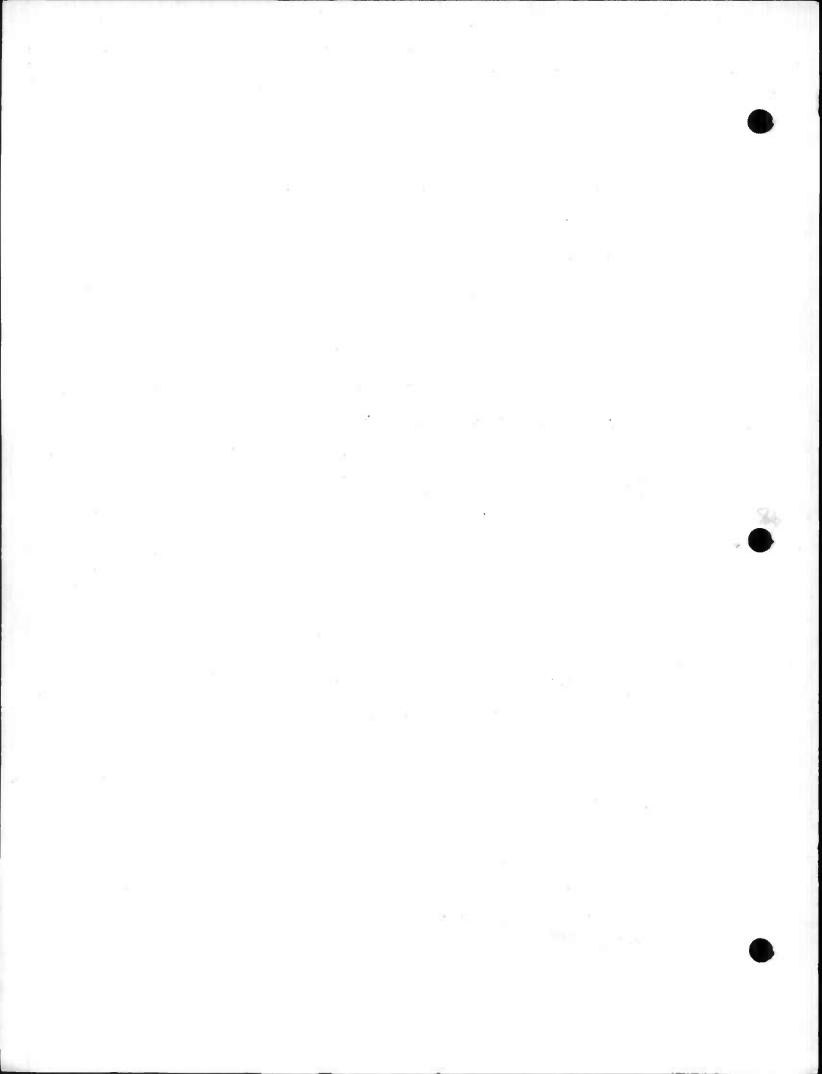
28a. DATE OF INJURY

32171 5

21793 WALKERSVILLE MD

-6006 9 W FRSDURICK ST. 31. DATE FILED (Morth, Day, Year)
MAY 1 7 1995 32 REGISTRAR'S SIGNATURED FILLS D'AUGUST RONGELL

95



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4 Homicide

29a. CERTIFIER (Check only one)

TO BE COMPLETED BY FUNERAL DIRECTOR

												90		196	2
FOR 1 - STATE REGISTRAR		STATE OF I	MARYLAND	DEPAR1 ERTIFI	TMEN CAT	T OF H	EALTH	AND I	MENTA						
1. DECEDENT'S NAME (First	Micidle Last)			CHITI	CAI	E OF	DEA	<u> </u>	1 nate	REG. NO			A 71146	OF OEATH	
SEMEN		Kic	LOVSKY	,					MONT	H D		YEAR		OF GEATH	
4. SOCIAL SECURITY NUM		5. SEX	6. AGE (in yrs. le		IE LIMBE	R 1 YEAR	IF UNDER	24 MDC		OF BIRTH				itate or Foreig	M
218-37-1763		1 🔀 M 2 🗌 F	63		MONTHS	DAYS	HOURS	MIN.	Jan	10 Year) 1	932	Ukra	y)_	unit or Foreig	,,,
9a. FACILITY NAME (If not in					9b. CIT	Y. TOWN C	R LOCATI	ON OF D				JNTY OF DE			
University	of Mar		spital			Ltimo						timor		ity	
10a. STATE	10b. COUNTY			10c. CITY	, TOWN	OR LOCAT	ION					1	10d, INS	IDE CITY	_
MD	Montg	omerv		Bro	ooke	evil	e					1	LIM	1797 S 2 NO	,
10e. STREET AND NUMBER	1101109	<u> </u>					ZIP COD	E			10g, CI1	TIZEN OF W			
18917 Alpen	glow L						20833				ÜS				
11. MARITAL STATUS 1 Never Married 2 🔀	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X	RMED NO	13.		cify Cubi	n, Maxica	in, Puerto	N? (Specify Yas Rican, atc.)	or No-			ican Indian, itc.	
3 Widowed 4 Divo	orced		on JAILO		-	, [] IE3	- (XINO	Specif	7.			Specif	wh:	ite	
(Specify onl	EDENT'S EDUC y highest grade	completed)	(C	ECEDENT'S L Give kind of wi D. Do NOT use	JSUAL Cork done	during mo	N st of worki	ng	168	. KIND OF BU	SINESS/IN	DUSTRY			
Elementary/Secondary (I	J-12)	Cotlege (1-4 or 5		ngine	er				1	Metall	urqy				
17. FATHER'S NAME (First, M	liddle, Last)			3			18, MOT	HER'S NA	_	Middle, Maiden					
Lev Kislovs	ky							D-		Kan	PVS	kava			
19a. INFORMANT'S NAME (1			19	b. MAILINO	ADDRES	S (Street a	nd Numbe	or Rural	ASYA Route Num	ber, City or Tow	n, State, Zi	ip Code)			_
Eugene K	islov	skiv	1	8917	Alpe	enq1	ow La	ane	Bro	okevi1	le M	D 208	333		
20a. METHOD OF DISPOSIT	ION		20b.PLACE	ANDDATEO	F DISPO	SITION (Na			DAT	_		- City or Tov			_
1 Donation 5 Other		oval from Stata		metory or oth			rdo	16	5-	8 01n	ev M	D			
21. SIGNATURE OF FUNERA	L SERVICE LIG	ehsts:		1 1:40-141	22	NAME AL	D ADDOE	SE OF EA	CII ITY			•			
CO. 1	æk									ral Di ke Ro			/m 2/	0852	
23. PART I. Enter the d	Isaasaa Dr.C	omolications the	t caused the d	eeth Do o					_						
ahock, pr h	eart fallure. L	lat only one cau	ise Dn each lin	B.	or erne	r the mo	de oi dy	ing, suc	n aa can	disc or reap	ratory si	rrest,	Int	proximate erval Betv	veen
IMMEDIATE CAUSE (Fir disease or condition	nal	1												set and D	
resulting in daeth)	→ ,	DUE TO	CANCE	01151105.05									151	month	15
		002 10	(OH AS A CONSE	OUENCE OF);										
Sequentially list condit if any, leading to imme	diate	DUE TO	(OR AS A CONSE	OUENCE OF):					-					
cause. Enter UNDERLY CAUSE (Disease or injuthat initiated eventa resulting in death) LAS	iry o	DUE TO	(OR AS A CONSE	OUENCE OF)):		_						-	_	
aveni, End		i		-	-					-					
PART II. Other algnifica	nt conditions	contributing to	death but not	reaulting in	the u	nderlying	cause	given in	Part I.	24s. WAS AN		24b.	WERE AU	TOPSY FIND	NGS
Chmonic C	Obstru	ctire i	Puliner	1000	an's	car	e "			PERFOR	p		COMPLET	E PRIOR TO TION OF CAU	SE
									_	1 1 163 2	Z NO		OF DEATH	/	
DID TOBACCO U	ISE CONTR	RIBUTE TO CA	USE OF DE	TH YE	s DX	NO [LINC	ERTAIL	— П				I LI TES	2 N O	
25. WAS CASE REFERRED T		DOIL TO CA		CE OF DEATH			0140	ENIMI	4 1						_
EXAMINER?		HOSPITAL:	ER/Outpatient		OTHE		5Пр.	eldance	6 1 Oth	or (Specific)					
27. MANNER OF DEATH		26a. DATE OF	INJURY	28b. TIME	OF	28c. INJ	JAY AT	- STORTFOR	_	SCRIBE HOW I	NJURY OC	CCURED			_
~	Pending Investigation	(Month, D	ay, Year)	INJU	M		RK? ES 2	NO							
2 Decident	Could not be	28s. PLACE O	F INJURY — At he atc. (Specify)	ome, farm, st	reet, fac	tory, office				CATION (Street I		or or Rural R	oute Numi	ber,	
4 Mambalds	determined	wantaning,	(opoony)						Uniy	or Town, State)					

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 85

Bultimore

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8 Could not be determined

MEDICAL EXAMINER:

ME

296. SHENATONE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

CHARLOTTE South

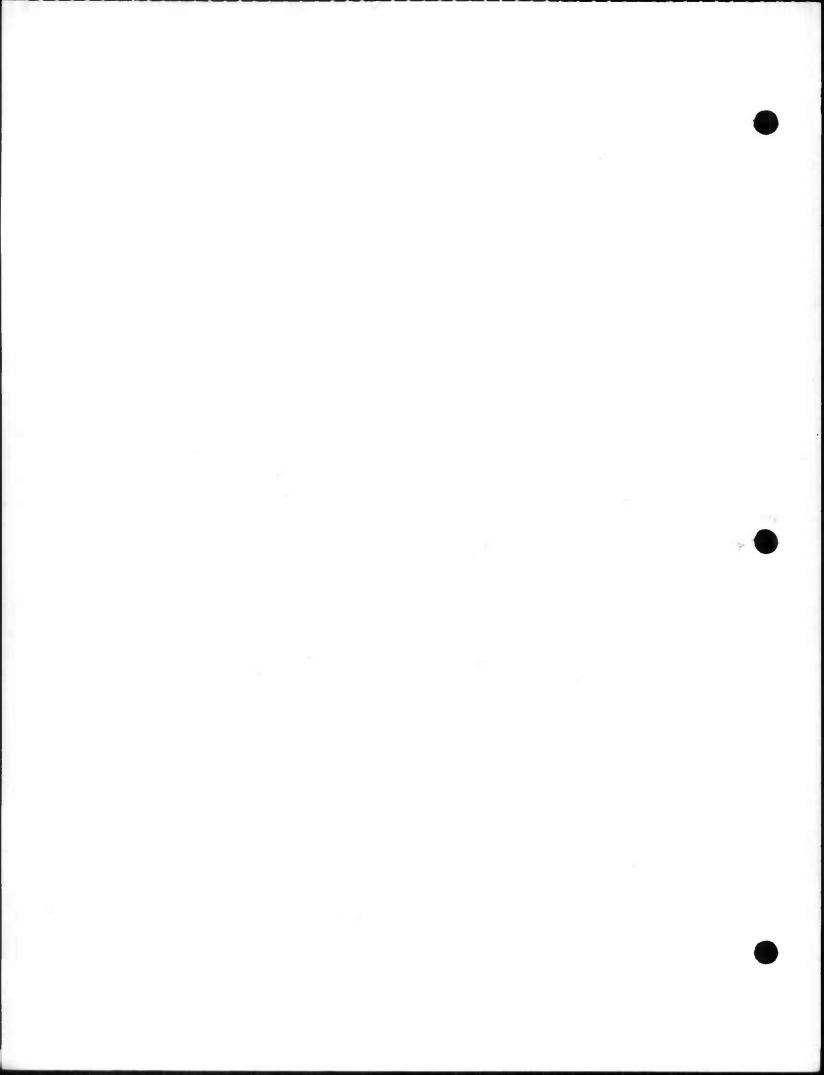
MAY 12 1995

32. BEGISTRAR'S SIGNATURE
Julia Danchar Randall

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(s) and manner as stated.

ST

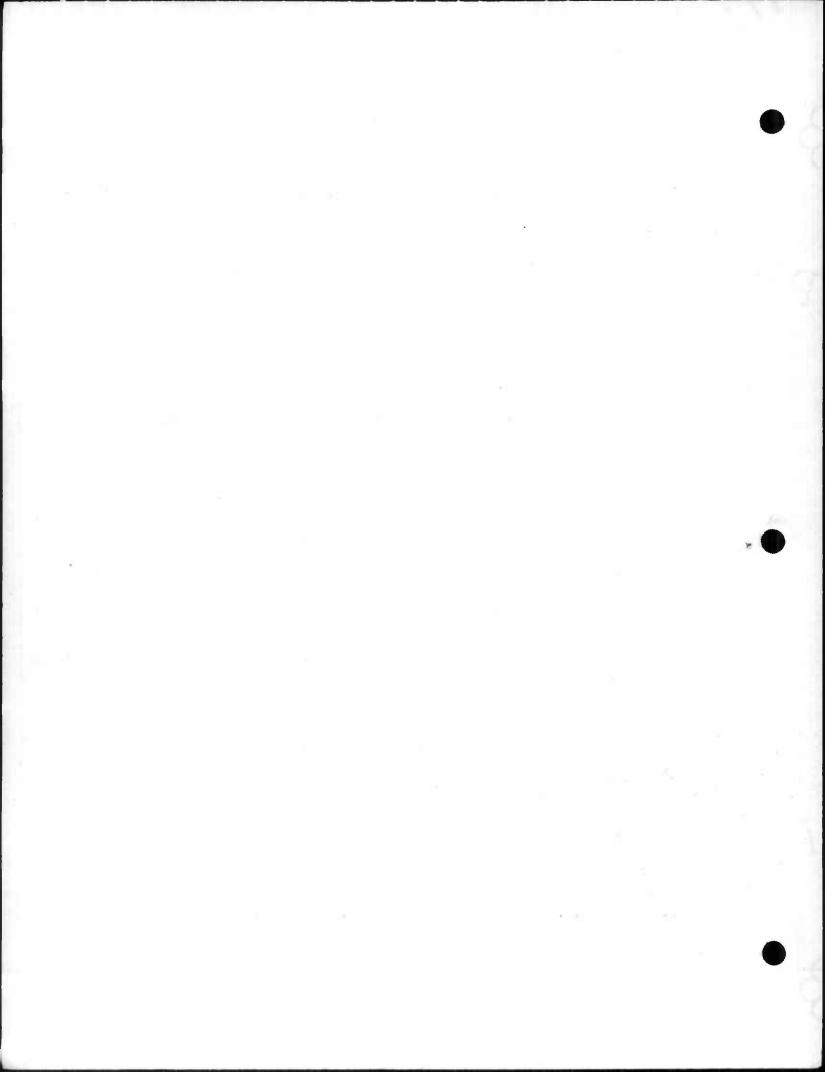


BALTIMORE, MARYLAND 21215-0020
BALTIMORE
松
O. BOX 68760
RECORDS, P.
OF VITAL RE
DIVISION O

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG NO

	1 - FOR STATE OF MARYLAN		MENT OF HEA		ENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH	3. TIME OF DEATH							
	LAKSHMIPATHI DUTT			1995 YEAR	9:23 a					
	N/A 1⊠ M 2 □ F 66	160		URS MIN.	(Month, Day, Year) ept. 25,	Co	ATHPLACE (State or Foreign untry) India			
æ	8e. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR L		TH	9c. COUNTY O				
DIRECTOR	6162 Springhill Terrace, #302 Greenbelt PRINCE GEORGES RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	, todakira paditam									
FUNERAL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?									
R	Plot #6, Sector #1 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	I C ADMED		30017		India				
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never Married 2 Married 3 FORCES? 1 YES IF YES, GIVE WAR OR DATE	If yes, specify	ENT OF HISPANIC Cuben, Mexican, () NO Specify:	8	ACE — American Indian, lack, White, atc. sectly: Indian					
8	15, DECEDENT'S EDUCATION (Specify only highest grade completed)	6a. DECEDENT'S US	UAL OCCUPATION done during most of	working	16b. KIND OF B	USINESS/INDUSTR				
COMPLET	Elementery/Secondary (0-12) College (1-4 or 5+)	Me. Do NOT use n	etired.)	working						
MP E	12 4	Veterina				nary Med	icine			
E C	Sambatri Mahamuni Kalluri				(First, Middle, Meide	n Sumame)				
8	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AD		nasoya	Sripada	wn State Zin Code)				
TO BE CON	Phani-Kumar Atri Kalluri 6162 Springhill Terrace, #302, Greenbelt, MD 20770									
180	20a. METHOD OF DISPOSITION 1	LACE AND DATE OF I	place) Cremator	f		OCATION - City or				
	21, SIGNATURE OF FUNERAL SERVICE LICENSEE	esapeake		DORESS OF FACIL		rtsville	, Maryland			
	> Elen Il. Rap	yo	Rapp F	uneral S	Services					
	er Spring	Approximats								
	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death									
, 1110	disease or condition resulting in desth) s. Acute Myocardial Infarction Out to (or as a consequence of):									
evolit,							> 2+yrs			
ATION	Sequentially list conditions, DUE TO (OR AS A C	Atheros	clerosis				Unk			
ERTIFICATION	cause. Enter UNDERLYING Diahotos	s Mellitu					10+yrs			
TIFIC	thet initieted events DUE TO (OR AS A Co						10.976			
ER	resulting in death) LAST									
AL CE	PART II. Other significant conditions contributing to death but	not resulting in t	he underlying cs	use given in Pa	rt i. 24a. WAS A	N AUTOPSY 2	4b. WERE AUTOPSY FINDINGS			
S	Recent Cerebrovascular Acc	rident			PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
: MEC						4	OF DEATH? 1 YES 2 XNO			
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF			JNCERTAIN						
YSICI/	EXAMINER? HOSPITAL:	PLACE OF DEATH (THER:							
	1 🖒 YES 2 🗌 NO 1 🗀 Inpetient 2 🗆 ER/Outpetk 27. MANNER OF DEATH 28s. OATE OF INJURY	ent 3 DOA 4	☐ Nursing Home 5							
BY PH	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJUR	M 1 YES		Bd. DESCRIBE HOW	INJURY OCCURED				
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, street	et, factory, office	26	Bf. LOCATION (Street City or Town, State		al Route Number,			
AP	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) MEDICAL EXAMINER: On the basis of examination as						e(a) and manner as stated			
D BE COMP	29b. SIGNATURE AND TITLE OF CERTIFIER		290	LICENSE NUMBE	R	29d. DATE SIGN	ED (Month, Day, Year)			
10	30. NAME-AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	AUTHA OT CO.		25925		► Mag	5,1995			
	J. Berger M.D. #205, 7720 W.	isconsin		thesda,	MD 208	14	•			
	31. DATE FILED (MONTH, Day, Year) MAY 08 1995 Julia Davidson	Randa II.								
							DHMH.18 Pay 12			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	ΙE
	CI	ERTIFICATE	OI	F DEAT	TH		REG NO	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTM	ENT OF H	EALTH AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)				DEATH	2. DATE OF DEATH	0.	3. TIME OF DEATH		
	Elizabeth Mar	ian Bradlev	King		05 07	1995 YEAR	10:10 A M			
		SEX 6. AGE (In yrs. lest		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign			
	367-18-4425	□ M 2 □ XF 86	YRS. MONT	THE DAYS	HOURS MIN.	(Month, Day, Year) September		ntry)		
	9e. FACILITY NAME (If not institution, give street		9b.	CITY, TOWN O	R LOCATION OF DI		9c. COUNTY OF	York		
NC	Villa Rosa Home		Mi	tchell	ville			George's		
5	RESIDENCE OF DECEDENT						Trrince	000280 0		
H	10a. STATE 10b. COUNTY			WN OR LOCATI				10d. INSIDE CITY LIMITS?		
0	Maryland Prince	George's	Mitch	ellvi				1 TYES 2 NO		
FUNERAL DIRECTOR				101.	ZIP CODE			WHAT COUNTRY?		
N	3800 Lottsford-Vist				20716		U.S.			
3	1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. ARN FORCES? 1 YES 2 NO	D	If yes, spe	cify Cuban, Mexica	NC ORIGIN? (Specify Y	va or No— 14. RA	CE — American Indian, ck, White, atc.		
BY	3 🔀 Widowed 4 🗋 Divorced	IF YES, OIVE WAR OR DATES		1 TYES	2X NO Specify	<i>y</i> :		ocify:		
G	18. DECEDENT'S EDUCATION	ON 18e. DEC	EDENT'S USUA	L OCCUPATIO	N -	16b. KIND OF B	USINESS/INDUSTRY	ite		
E	(Specify only highest grade com Elementary/Secondary (0-12) Co	pleted) (Giv ollege (1-4 or 5+)	e kind of work d Do NOT use retir	one during mos ed.)	t of working	3,500				
P	12	CONTRACTOR OF THE PROPERTY OF	etary			Fede	ral Gove	rnmont		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle, Meide		United		
BE (Leverne Br	adley		i	Alice	Cook				
TO B	19e. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADDI	RESS (Street an	d Number or Rural I	Route Number, City or To	wn, Stere, Zip Code)			
-	Ann G. Appleyard	60	007 Men	itana S	Street	New Carro	llton,Mar	yland 20784		
	20a. METHOD OF DISPOSITION 1 🖾 Burlel 2 🗌 Cremetton 3 🗎 Removal	from State cemstery crem	ND DATE OF DIS	ace!			OCATION — City or	Town, State		
	4 Donetton 8 Other (Specify)		ivet (emeter			shington,	D.C.		
	21. SIGNATURE OF PUNERAL BERVICE LICENS	1/1/1/			ADDRESS OF FA	cury 11ins Fund	eral Home	. Inc.		
	Illach .	Villen						,MD 20901		
	23. PART i. Enter the diseases, or comp	plications that caused the des	th. Do not a	ntar tha mod	a of dying, auc	h ss cardiac or rea	piratory arrast,	Approximata		
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death									
	disease or condition resulting in death) s. DUE TO (OR AS A CONSEQUENCE OF):									
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQU	JENCE OF):							
CERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSECU	JENCE OF:							
E	resulting in death) LAST		,					į l		
S	d									
¥.	PART II. Other significant conditions co	ontributing to death but not ra	sulting in the	undarlying	causa given in	Part I. 24a. WAS A	N AUTOPSY 24 DRMED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
20	- Hype	Thyroide	->r-	1		1 _ YES	2 NO	COMPLETION DF CAUSE OF DEATH?		
M		_/				_ 1		1 TYES 2 NO		
Ä	DID TOBACCO USE CONTRIBU				UNCERTAIN	1 🗆				
PHYSICIAN: MEDIC		OSPITAL:	OF DEATH (Ch	JER:						
IYS	1 VES 2 NO 1	Inpatient 2 ER/Outpatient 3	DOA 4	Nursing Home		8 Other (Specify)				
	1 Natural 8 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJU WOR	IC?	28d. DESCRIBE HOW	INJURY OCCURED			
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY — At hom	a form atmost		S 2 NO					
	4 Homicide B Could not be	building, etc. (Specify)	e, rarm, screet,	lectory, office		281. LOCATION (Stree City or Town, State		Floute Number,		
COMPLETED	290. CERTIFIER									
MP	(Check only one) 2 MEDICAL EXAMINED: OF	To the best of my knowledge, dest	h occurred at t	he time, date e	nd place, end due	to the cause(e) end m	enner se stated.			
8		n the beels of examination and/or in	restigation, in i				ind due to the ceuse	(e) end menner se stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	110.	10	1	29c. LICENSE NUN	- 4 -	29d. DATE SIGNE	D (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO CO	MO STED CALLED OF STEEL	- 11/	4	11/2	863	5.	7.43		
	17. A. MA-1 A11) -	1.1 / AAC		love	01	1/	0 4.	2 2 2200		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	Lario	000	po.	Meva	5 111	20785		
- 4		Julia Davidson Rarda								
	M(/\V 1 () 100E 4	II IIA dTGINPLIANINA ILAAN-I	//.							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

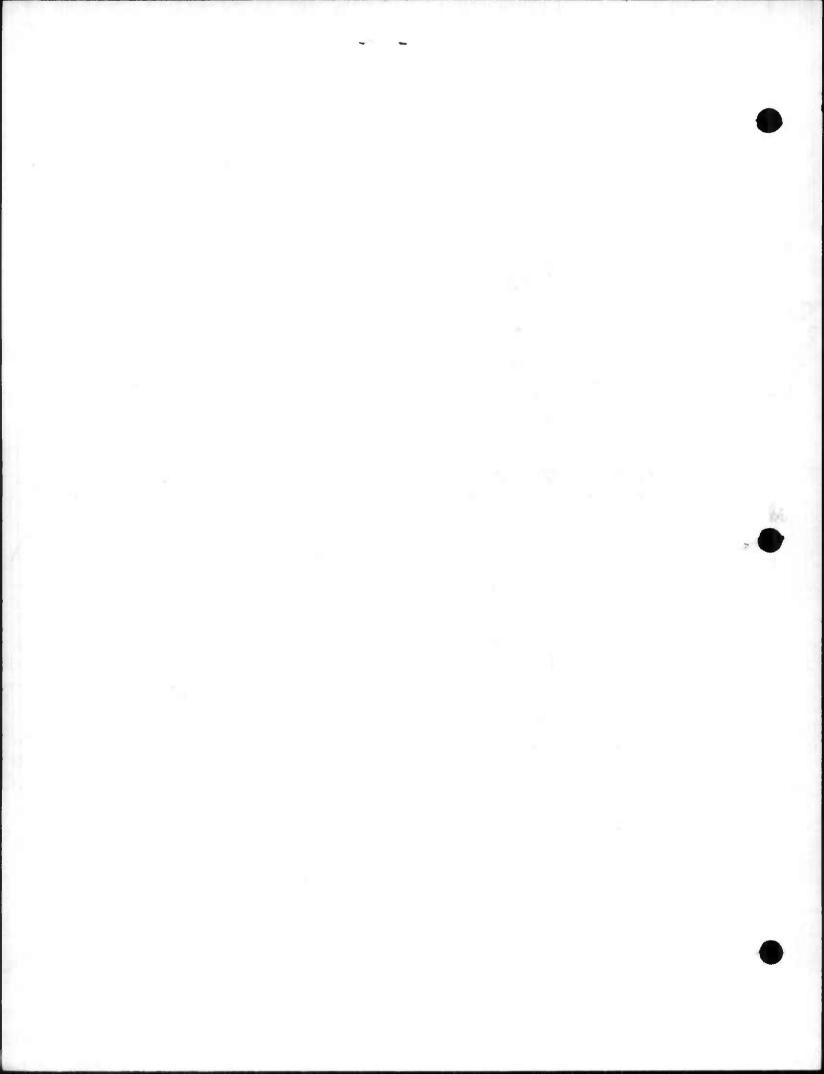
	_	REGISTRAN			OL	-4 4 4 44	IUA	IE OF	DEA			REG. NO.			
	į	DETACONY TRAVEL WITH YEAR									3. TIME OF DEATH				
	1									MAY 1, 1995 12:16 P					
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE 1 🖂 M 2 🗆 F 84			yrs. last	t birthday) YRS.	IF UN	DER 1 YEAR	IF UNDE	MIN.	7. DATE OF BIRTN (Month, Day, Year)		BIRT NPLACE (State or For Country)		()
				04		rns.	05.0	TTV TOWN C	D I OCAT	ION OF DE		15 19			YLAND
a		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT													
a OF	3	RESIDENCE OF DECEDENT									11				
DIRE		10a. STATE 10b. COU				10c. CIT		N OR LOCAT							10d. INSIDE CITY LIMITS?
	_		RETT				0/	AKLANI)						1 YES 2 NO
FIINERAL		10e. STREET AND NUMBER	DOAD					10f	ZIP COO						HAT COUNTRY?
Į.		2465 TABLE ROCK					_		215				US		
	- 11	1 Never Married 2 Married	12. WAS DECEDED FORCES?	t YES	2 XX N	MED		If yes, spe	city Cubi	en, Maxica	NIC ORIGIN? (in, Puerto Ric		or No-	Black	— American Indian, , White, etc.
8	- 111	3 X Widowed 4 Divorced	IF YES, GIVE	WAR OR DAT	EŞ			1 [] YES	2 K) NO	Specify	γ.			Specif	WHITE
<u> </u>		15. DECEDENT'S E (Specify only highest gra		t	16n. DEC	CEDENT'S	USUAL	L OCCUPATIO	N et of worki	na	16b. K	IND OF BUS	SINESS/IND		
1		Elementary/Secondary (0-12)	College (1-4 or 5	+)	lite.	Do NOT us	se retire	d.)	or or work			TO A T		CART	ON
once.		12			WE	ELDEF	λ					ETAL 1		CATI	ON
E C	- 111	17. FATNER'S NAME (First, Middle, Last) CHARLES FRANKL	N KELLEY	7						NER'S NA LANCI	ME (First, Mid	die, Maiden	Sumame) BENS	ON	
E B	,	19a. INFORMANT'S NAME (Type/Print)	.N KLIDELI.		100	MAHING	ADDR	ESS (Street o			Route Number,				
TO BE COM	2	MRS. VICKIE BERI	RY					r. Al							21550
st De		20a. METHOD OF DISPOSITION 1 XX Buriel 2 Cremation 3 Re	mount from State	20b. P	LACEA	NDDATE	OF DISF	POSITION (Na	me of		DATE	20c. LO	CATION —	City or Tox	wn, State
medical examiner must		4 Donetion 5 Other (Specify)		Cemer	AII	KVIEV	V CI	ÉMETEI	RY		5/4	OAK	LAND,	MAR	YLAND
aline		21. SIGNATURE JUNEAU SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY P.O. BOX 243													
СХЭ		DURST FUNERAL HOME - OAKLAND, MD 21550													
odica	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory shock, or heart failure. List only one cause on each line.										ratory arr	rest,	Approximate		
E 3		IMMEDIATE CAUSE (Final													
it, the		disease or condition resulting in death) a. CONGESTIVE HEART FAILURE 2 YEARS									2 YEARS				
event,		DUE TO (OR AS A CONSEQUENCE OF): CARDIOMYOPATHY SEVERAL YEARS													
CATION		Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
TAT		CORONARY ARTERY DISEASE													
ar other		CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
9 1		resulting in death) LAST	d						_						
injury,		PART II. Other significant conditi	ona contributing to	daath but	t not re	esulting	in tha	undarlying	cause	given in	Part I. 2	4s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
any inju												PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
5 I W	1 16										_ '	U 1E3 €	WY HO		OF DEATH?
AN: M		DID TOBACCO USE	CONTRIBUT	E TO	CAU	SE OI	F DE	ATH Y	/ES [7 NO	D XI				
item 2		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					26. PL			eck only one)				
		t YES 2 X NO	1X Inpatient 2		lent 3	□ DOA	OTH 4 □ 1		• 5 □ R	asidence	8 🗆 Other (Specify)			
P g,		27. MANNER OF DEATN 1 X Natural 5 Pending	28a. DATE O (Month,	F INJURY Day, Year)		28b. TIM	E OF JURY		RK?	75	28d. DESCI	RIBE NOW I	NJURY OC	CURED	
mar N		2 Accident Investigatio	28a PLACE	OF INJURY -	- At hor	me ferm	etro et 1		ES 2 [NO	284 LOCAT	ION /Steam	and Mumber	0 0	to de Monte.
28 is		3 Suicide B Could not to determined	building	, atc. (Specify	1)	, , , , , , , , , , , , , , , , , , , ,	otroat, i	tactory, office				Town, State)	Ind Number	or murai m	loute Number,
E		29a. CERTIFIER t CERTIFYING PN	SICIAN: To the hest of	d my knowler	doe des	oth occum	ad at th	ne time date	and plan	and due	to the source	/a\ and mar			
= 3															and manner as stated.
MPORTANT:	- 11	296. SIGNATURE AND TITLE OF BERTIE								ENSE NUM					(Month, Day, Year)
AP S		Faul Da	niel	m	10	Oon	7		H26				•		2, 1995
₹ 2		30. NAME AND ADDRESS OF PERSON		_						-					
		PAUL DANIEL MII	LER, D.O.	, 225	55 0	G. W.	P.	laza I	Rout	e 135	5, Oak	cland	, MD	215	50
1/		MAY 3 1995	32. REGISTR												
U		MAY 3 1995	fills die	urdson-A	Tark	1			-						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

10 THE HUSPITAL URALLENDING PHYSICIAN: The law requires that the death certificate be executed writing a nount and feath. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH	-	3. TIME OF DEATH					
	ETHEL	MA	- VIIIII	KEY	MAY 10,	1995 YEAR	4:00 AM					
	The state of the state of		140	UNDER I YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIFTT	HPLACE (State or Foreign					
	215-36-2996 1 9e. FACILITY NAME (If not institution, give street	M 2 X F 8	4 YAS.	CITY, TOWN OR LOCATION OF	DEC. 31,		SHINGTON, D.C.					
DIRECTOR	PHYSICIANS MEMOI			LAPLATA	DEATH .	CHARL						
EC	10e. STATE 10b. COUNTY		10c, CITY, To	OWN OR LOCATION			10d. INSIDE CITY					
H	MARYLAND CHAR	I E C					LIMITS?					
	10e. STREET AND NUMBER	LES	NEW	101, ZIP CODE			1 TES 2 NO					
FUNERAL		DOAD				10g. CITIZEN OF						
NE I	#12355 ROCK POINT I			20664		UNITED	STATES					
FU	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DECENDENT OF HISP If yes, specify Cuban, Maxi		or No — 14, RAC Blee	E — American Indian, ck, White, atc.					
ВУ	3 AWidowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES 2 NO Spec		Spec	elfy:					
		- I					BLACK					
1	15. DECEDENT'S EDUCATI (Specify only highest grade com	npleted)	(Give kind of work	done during most of working	16b. KIND OF BU	SINESS/INDUSTRY						
٣		College (1-4 or 5+)	ilfe. Do NOT use re	•								
MP	6TH GRADE		DOMEST		PRIVA							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S I	IAME (First, Middle, Meiden	Surname)						
BE	DR. WILLIAM E. GALE	ES		FRANCE	S ANN DYSON	N GALES						
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Number or Rura	I Route Number, City or Tow	n, State, Zip Code)						
F	JOAN K. HALL		#15530 V	ILSON ROAD, N	EWEURG, MAH	RYLAND 2	20664					
	20a. METHOD OF DISPOSITION		PLACE AND DATE OF D	SPOSITION (Name of	DATE 20c, LO	CATION — City or To						
	1X Burial 2 Cremation 3 Ramoval	SH SH	tery, cremetory or other LLOH CHUR(CH CEMETERY 5/	13/95 NEI	VBURG, MA	RVIAND					
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	0	22. NAME AND ADDRESS OF	ACILITY		MELLIAND					
	sydia Chi	until for	Anson	THORNTON FUN								
_	INDIA C. THORN			#3439 LIVINGS	TON ROAD, IN	NDIAN HEA	D,MD. 20640					
	23. PART I. Enter the disesses, or com shock, or heart feilure. List	plications that caused	the deeth. Do not	enter the mode of dying, su	ch se cerdlec or resp	Iratory errest,	Approximete					
-1	IMMEDIATE CAUSE (Finel	/ Course on as	N N		1		Interval Between Onset and Death					
	disease or condition resulting in death)											
	s	S. DUT TO (OR AS A CONSEQUENCE OF):										
ا ح	- Kenst Failmed. I 12 2 1 Dem											
ᅙ	Sequentially list conditions, If any, leading to immediate											
₹ I	cause. Enter UNDERLYING	170	wypr	Low	1	_						
Ĕ	CAUSE (Disease or Injury that Initiated events	DUE TO LON AS A	ромявайвись ог	1.	1							
CERTIFICATION	resulting in death) LAST	1778	cut en	Mellin	\sim							
AL	PART II. Other significent conditions co	ontributing to deeth bu	it not resulting in ti	ne underlying ceuse given i	n Part I. 24a. WAS AN	AUTOPSY 24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO					
용					1 D YES #		COMPLETION OF CAUSE OF DEATH?					
W					1		1 TES 2 NO					
=	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO □ UNCERTA	IN 🗆							
Y.	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH (C									
200		OSPITAL: Inpatient 2 ☐ ER/Outpu		HER: Nursing Home 5 - Residence	4 C On (C#)							
PHYSICIAN: MEDIC	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIME OF		28d. DESCRIBE HOW I	N III BY OCCUPED						
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WORK? M 1 YES 2 NO	200. DEGOTING HOW	NIDON'I OCCORED						
B	2 Accident Investigation 3 Suicide Could not be	26s. PLACE OF INJURY	At home form stree		204 LOCATION (O							
	4 Homicide 6 Could not be determined	building, atc. (Speci	y)	t, ractory, offica	281. LOCATION (Street a City or Town, State)	and Number or Hurai i	Houte Number,					
<u></u>												
		V: To the hest of my knowle	dge, death occurred at	the time, data and place, and de			the time, date and place, and due to the cause(a) and manner as stated.					
린		(Check only one) 2 MEDICAL EXAMINER: On the Deals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and										
OMPI	(Check only CHITIFYING PHYSICIAN		and/or investigation, in	my opinion, death occured at th	e time, date and place, an	d due to the cause(e	e) end manner as stated.					
	(Check only CHITIFYING PHYSICIAN		and/or investigation, in	my opinion, death occured at the		d due to the cause(o						
8	(Check only 2 MEDICAL EXAMINER: O		and/or Investigation, in									
8	(Check only 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER		W	29c/Libense N								
TO BE COMPLETED	(Check only 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER	on the basis of examination	W	29c/Libense N								
8	(Check only 2 MEDICAL EXAMINER: 0 29b. SIGNATURE AND TITLE OF CERTIFIER	on the basis of examination	TN (ITEM 27) (Type, Prin	29c/Libense N								



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed it.	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completed med in by the funeral director, page 5 should be detached.	State	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MA			TMENT OF			MENTAL	HYGIEN REG. NO.			
	Decement's Name (First, Middle, Last) Dav.	id B. K	eefer					2. DATE O MONTH May	12	19	YEAR 95	3. TIME OF DEATH 11:15 P M
	4. SOCIAL SECURITY NUMBER 216-20-5066	1X M 2 - F	6. AGE (In yrs. last birthday) 67 YRS.		MONTHS DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Ybar) Sept 1, 1				yland
TOR	96. FACILITY NAME (If not institution, give street end number) 2818 Pinewick Road RESIDENCE OF DECEDENT				Ellicott City							
DIRECTOR	Maryland Hor	ward	3000		TY, TOWN OR LOCATION Ellicott City							10d, INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 2818 Pinewick Road				101, ZIP CODE 21042 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year)			(Specify Van	United States			
ΒY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 ☐ YES 2 ▼ NO Specify:			Blac	k, White, etc.			
COMPLETED	(Specify only highest grade completed) (Give killed by the Elementary/Secondery (0-12) College (1-4 or 5+)			CEDENT'S ive kind of v Do NOT us				& Plastics ties Inc.				
BE CO	17. FATHER'S NAME (First, Middle, Lest) David B. Keefer Sr. Dorothy Wise											
2	190. INFORMANT'S NAME (Type/Print) Jean F. Keefer 191. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2818 Pinewick Road Ellicott City, MD 21042											
	20s_METHOD OF DISPOSITION * Burial 2 Cremation 3 Remo 4 Donation 8 Other (Specify)		Crest	of dispos Lawn	Cemete	ery	ı	-				lle, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	7. Foewn	de		Har		Witz]	ke Fu	neral Pike			City 21043
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heart fellure. List only one cause on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Bue to (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death Due to (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. Due to (or as a consequence of):											
CERT	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
SICIAN: MEDICAL	PERFORMED? 1 VES 2 NO						AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)											
ву рну	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? WORK? M 1 VES 2 NO					CCURED						
0	2 Accident investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office bullding, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)						Route Number,					
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIE	2061,-	mo			29c. L	13	S E	8	29d. D/	S/L	0/Month, Day (Year)
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (IT)	EM 27) (Typ	e. Print)							/

DEATH (ITEM 27) (Type, Print)
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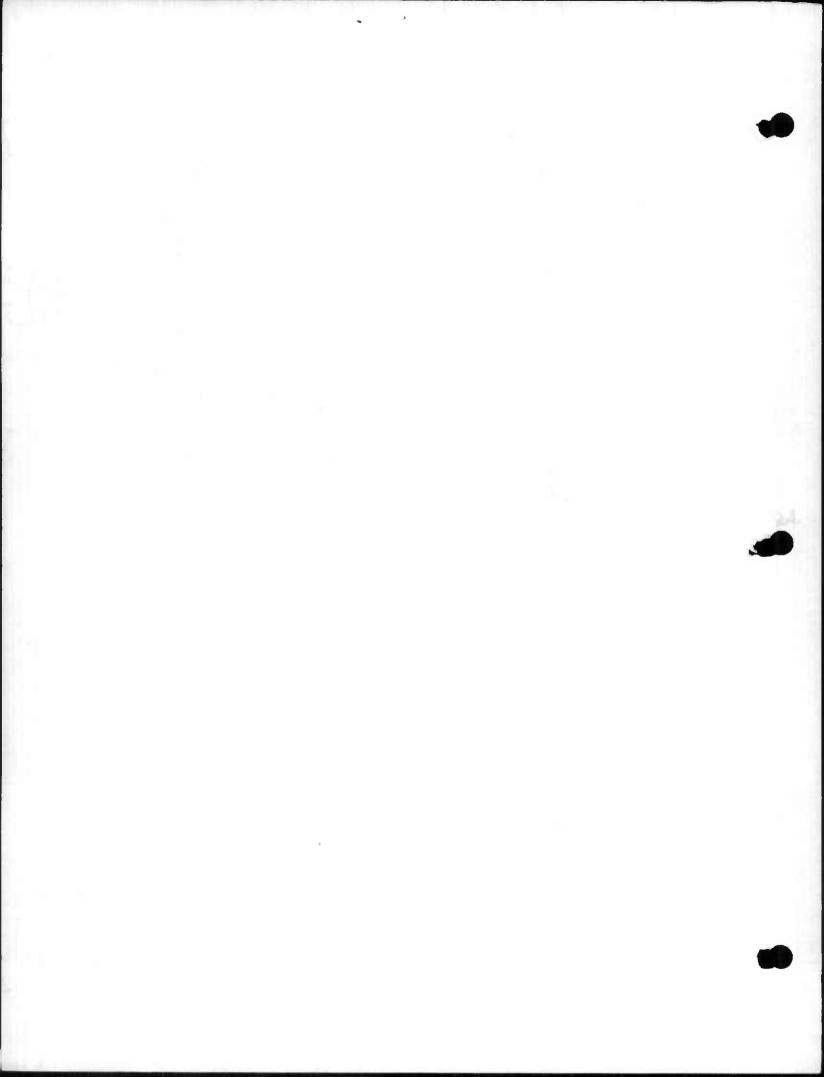
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30. NAME AND ADDRESS OF PERSON WHO
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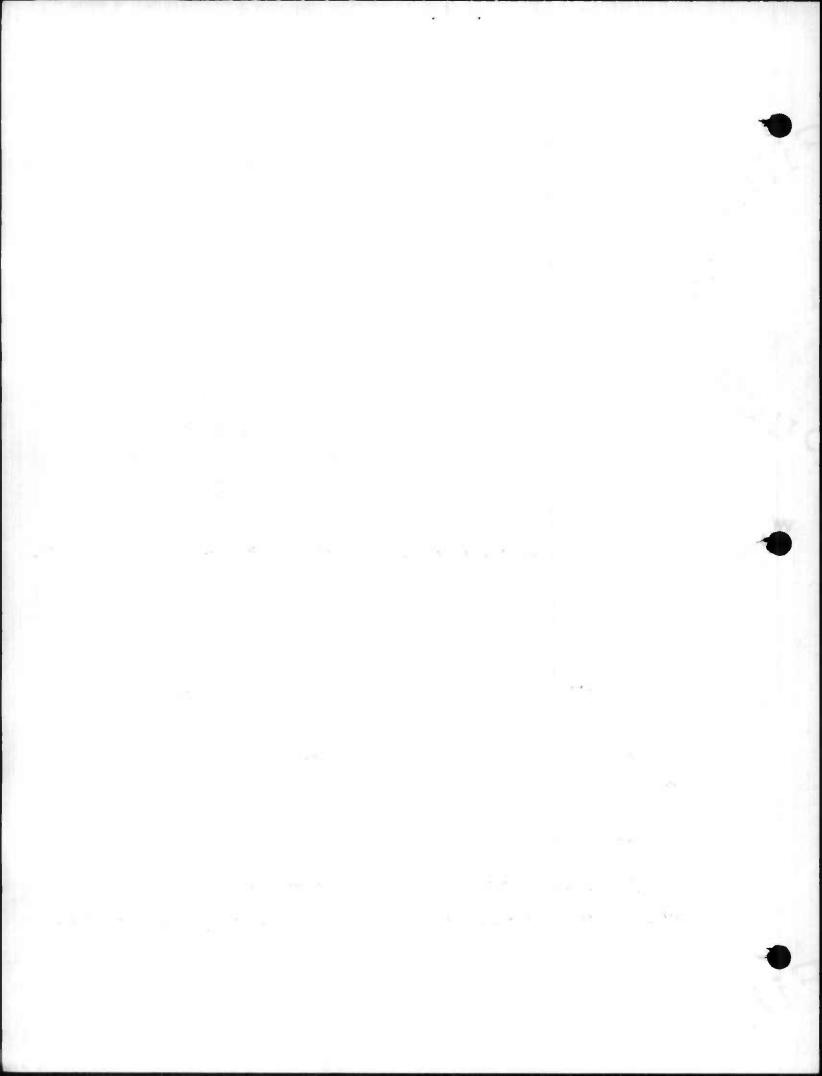


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DRDS, P.O. BOX 13146,	that the death certificate be executed with
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ECORDS, P.O. BOX 13146,	unless that the death cartificate be executed with
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VITAL RECORDS, P.O. BOX 13146,	AM: The law requires that the death certificate he executed with
F VITAL RECORDS, P.O. BOX 13146,	CICIAN: The law recules that the death certificate be rescutted with
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ION OF VITAL RECORDS, P.O. BOX 13146,	United Duverolass: The fau requires that the death certificate be executed with
SION OF VITAL RECORDS, P.O. BOX 13146,	TEAIDING DUVELCHAN: The law requires that the death certificate be rescuted with
ISION OF VITAL RECORDS, P.O. BOX 13146,	ATTENDING BUYCLOIAN: The issurables that the death certificate be rescuted with
IVISION OF VITAL RECORDS, P.O. BOX 13146,	o ATTENDAG BUVELLIAM: The issurance that the death certificate be rescuted with
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	one arrestorate buyer has the feath the feath carrierate be resecuted within the base farm. Page 6 may be retained by the hospital or attending other

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within L-Yeurs after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crimition, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTIF	RTMENT OF	HEALTH AND F DEATH	MENT/	AL HYGIENI REG. NO.			
1	1. OECEDENT'S NAME (First, Middle, Last)	·				MONTH DAY YEAR			3. TIME OF DEATH	
BY FUNERAL DIRECTOR	Raymond J	(In yrs. last birthday)	t birthday)			y 13	19	95 BIRTHS	LACE (State or Foreign	
	141-20-0429	1 X M 2 - F 7	5 YRS.	MONTHS DAY	S HOURS MIN	Ja	n 5, 19		Penr Penr	nsylvania
	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF Ellicott City Howa						
	4121 Fonthill Dr	ive		ELL:	ty	Howai			1	
	10e. STATE 10b. COUNTY		10c. C	TY, TOWN OR LO					10d. INSIDE CITY LIMITS?	
	Maryland How	ard		Ellico					1 YES 2 NO	
	10e. STREET AND NUMBER 4121 Fonthill Drive			10f. ZIP CODE 21042						AT COUNTRY?
	4121 FORTHILL DRIVE 11. MARHTAL STATUS 12. WAS DECEDENT EVER IN U.S. AR			40 990		MAID (Procedly Mon			States	
	1 Never Married 2 Married 3 X Widowed 4 Olvorced 1 Never Married 2 Married 3 X Widowed 4 Olvorced			13. WAS DECENDENT OF HISPANIC ORIGIN? If yes, specify Cuben, Mexican, Puerlo Ric 1 YES 2 X NO Specify:				01110-	Black, Specify Whi	American Indian, White, etc.
E	16. OECEDENT'S EDU- (Specify only highest grade		16a. DECEDENT	'S USUAL OCCUP	ATION most of working	10	Sb. KINO OF BUS	INESS/IND	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) 4 Electrical Engineer					Westinghouse Electric			
OM	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAME (First, Middle, M.						
BE C	Frank Kowal	esky			Lou			ting		
TO B	19e. INFORMANT'S NAME (Type/Print)			et and Number or Ru						
F	Susan K. Bauer				ers Hill				_	
	20e. METHOD OF DISPOSITION 1 K Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place), ROSENILL CEMETERY May 16 Hagerstown MD									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEF 22. NAME AND ADDRESS OF FACILITY									
	Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043									
	23. PART i. Enter the diseases, of shock, or heert felliple. IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	complications that couse Liet only one couse on a	d the death. Do	not enter the	mode of dylng,	such ae ce	erdiec or respi	ratory ar		Approximate Intervel Between Onset and Death
ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
LC	PART II. Other significant conditions contributing to death but not resulting in the underlying of									
EDICAL		ns contributing to death	but not resultin	g in the under	lying cause giver	ı in Part i.			24b.	WERE AUTOPSY FINDINGS
MEDIC	NIA	ns contributing to death	but not resultin	g in the under	lying cause giver	in Part i.	24s. WAS AN PERFOI 1 TYES	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N: MEDIC	N/A	ns contributing to death	but not resultin	g in the under	lying cause given	n In Part i.	PERFO	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
CIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	but not resultin		lying cause giver		PERFOI	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IYSICIAN: MEDIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	tpetient 3 🗆 DOA	OTHER:	6. PLACE OF DEATH	I (Check only	PERFOI 1 YES 2	NO NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	EXAMINER? 1	HOSPITAL:	tpetient 3 DOA	OTHER: 4 Nursing	6. PLACE OF DEATH	Check only	PERFOI 1 YES 3	NO NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF CEATH	HOSPITAL: 1 Inpatient 2 ER/Ou 26e. DATE OF th/JURY (Month, Day, Vear) 28e. PLACE OF INJURY	spatient 3 DOA 26b. 1	OTHER: OTHER:	6. PLACE OF DEATH Nome Resider INJURY AT WORK? YES 2 NO	28d. E	PERFOI 1 YES 2	NO NO NO NO NO NO NO NO NO NO NO NO NO N	CCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJURY (Month, Dey, Veer) 28e. PLACE OF INJUR	tperient 3 DOA 28b. 1 Y — At home, ferr	OTHER: 4 Nursing TIME OF 28c INJURY M 1 n, street, factory,	6. PLACE OF DEATH Home Resider INJURY AT WORK? YES 2 NO offica	I (Check only) 28d. E 29f. L C	PERFOI 1 VES 3 ther (Specify) DESCRIBE HOW OCATION (Street filty or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	CCURED or Rural F	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
В	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only	HOSPITAL: 1 Inputlent 2 ER/Ou 26e. DATE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY building, etc. (Sp	tperient 3 DOA 28b. 1 Y — At home, ferr	OTHER: 4 Nursing TIME OF 28c INJURY M 1 n, street, factory,	6. PLACE OF DEATH Home Resider INJURY AT WORK? YES 2 NO offica	28f. L	PERFOI 1 VES 3 ther (Specify) DESCRIBE HOW OCATION (Street filty or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Pural F	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 10 CERTIFIER 10 CERTIFIER 11 CERTIFYING PHYS 12 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 130. NAME AND ADDRESS OF PERSON W.	HOSPITAL: 1 Inputlent 2 ER/Ou 26e. DATE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY building, etc. (Sp	tpetient 3 DOA 28b. 1 IY — At home, farr ecify) wiedge, death occion end/or investig	OTHER: 4 Nursing IME OF INJURY M 1 n, street, factory, urred at the time, atton, in my opinis	6. PLACE OF DEATH Nome Resider I INJURY AT WORK? YES 2 NO office dete end place, end on, death occured a	28f. L	PERFOI 1 VES 3 ther (Specify) DESCRIBE HOW OCATION (Street filty or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Pural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending 1 newsetgation 3 Suicide 6 Could not be 4 Homicide 6 Could not be 4 Homicide 6 Certifier (Check only One) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF FERSON WILLIAM AND ADDRES	HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJURY (Morth, Day, Vear) 28e. PLACE OF INJUR building, etc. (Sp BICIAN: To the best of my kno ER: On the basic of examination ER HO COMPLETEO CAUSE OF D	tpetient 3 DOA 28b. 1 Y — At home, ferr wiedge, death occ ion end/or investig	OTHER: 4 Nursing IME OF INJURY M 1 n, street, factory, urred at the time, atton, in my opinis	6. PLACE OF DEATH Home Resider INJURY AT WORK? YES 2 NO offica dete end place, end on, death occurred at	28f. L	PERFOI 1 VES 3 ther (Specify) DESCRIBE HOW OCATION (Street filty or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Pural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 10 CERTIFIER 10 CERTIFIER 11 CERTIFYING PHYS 12 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 130. NAME AND ADDRESS OF PERSON W.	HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Sp BICIAN: To the best of my kno ER: On the basic of examination ER HO COMPLETEO CAUSE OF D 32. REGISTRAR'S SIG	tpetient 3 DOA 28b. 1 Y — At home, ferr wiedge, death occ ion end/or investig	OTHER: 4 Nursing TiME OF 28c INJURY M 1 n, street, factory, urred at the time, ation, in my opinic	6. PLACE OF DEATH Home Resider INJURY AT WORK? YES 2 NO offica dete end place, end on, death occurred at	28f. L	PERFOI 1 VES 3 ther (Specify) DESCRIBE HOW OCATION (Street filty or Town, State)	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Pural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,

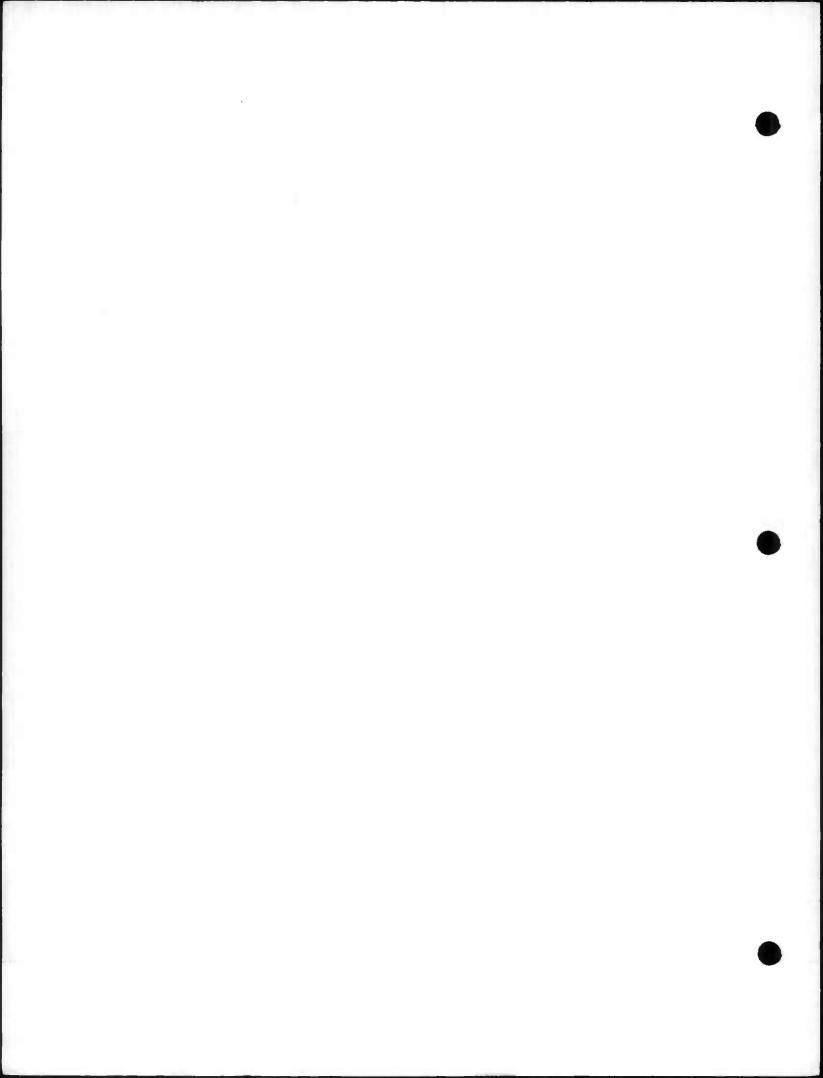
OHMH-16 Rev 1/89



TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death cutificiate be executed within The clark clearth. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAULY, PIRECTOR, After this certificate has been signed by the attention physicial and completely med in by the fundation of pages 3 should be detached for use as the buna-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPARTM			MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Y YEAR	3. TIME OF DEATH		
	Roy Edwin	Roy Edwin Kahl				May 5	11:00 p M			
	4. SOCIAL SECURITY NUMBER 5. S	EX 6. AGE (In yr		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	1995 8. BIRT	HPLACE (State or Foreign		
DIRECTOR	220–10–0948 1 5	YRS.	CITY, TOWN C	HOURS MIN,	May 8, 191	9c. COUNTY OF	yland			
	48 Negro Mountain Road			Accident			Garrett			
IREC	Maryland Garrett			10c. CITY, TOWH OR LOCATION ACCIDENT				10d, INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER		ACCI	101, ZIP CODE				1 YES 27 NO		
RA	48 Negro Mountain R	hen		101	21520		USA			
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify				E — American Indian,		
	1 Never Married 2 Merried 3 Widowed 4 Divorced Never Married FORCES? 1 YES 2 No			If yes, specify Cuben, Mexican, Puerto Ricen, etc.) t YES 2 NO Specify:				Black, White, etc. Specify: White		
COMPLETED	(Specify only highest grade completed) (Giv			CEDENT'S USUAL OCCUPATION ve kind of work done during most of working Do NOT use retired.)				BUSINESS/INDUSTRY		
7	Elementary/Secondary (0-12) College (1-4 or 5 +)			ian		Electr	ic			
0	17. FATHER'S NAME (First, Middle, Lest)		1000110	1411	18. MOTHER'S NA	ME (First, Middle, Melden				
BE C	John Kahl			Laura	Fresh					
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street e						
F	Mae F. Kahl		48 Negr	o Mount	tain Rd.	, Accident	, MD 21	520		
	20e. METHOD OF DISPOSITION 1 K Burlel 2 Cremetton 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of camplery, cremetory or other place) Z10n Lutheran Cemetery May 9,95 Accident, MD									
	21. SIGNATURE OF FUNERAL SERVICE LICENSE				D ADDRESS OF FA		cracitor	1110		
	Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536							21536		
	23. PART I. Enter the disasses, or comp shock, or heart failure. List of	lications that caused the	death. Do not	enter tha mo	de of dying, suc	h aa cardlec or reapl	ratory arrest,	Approximate interval Between		
	IMMEDIATE CAUSE (Finel						Onset and Death			
	disease or condition resulting in death)	Arrhyth	mia, A		Sudden					
Z	Ischemic Heart Disease							5 years		
Ĕ	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A COI			1					
음	CAUSE (Diseese of Injury	rotic Ca	rdio-V		Unknown					
CERTIFICATION	that initiated eventa pue TO (OR AS A CONSEQUENCE OF):									
	PART II Other electional conditions are	stabilities to death but				I				
CAL	PART II. Other algorificant conditions con Diabetes Mellit		ot resulting in t	he undarlying	g cauaa givan in	Part I. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC	Diapetes Meilit				X NO	OF DEATH?				
Σ	DID TOBACCO USE CO	NITPIRIITE TO C	ALISE OF I	DEATH N	/ES C N/			1 TES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL	NIKIBUTE TO CA	AUSE OF I		ACE OF DEATH (Ch	D X				
SIC		SPITAL: Inpatient 2 - ER/Outpatier	N 3 DOA 4	THER:		6 Other (Specify)				
¥	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME O	F 26c. INJ	URY AT	26d. DESCRIBE HOW II	NJURY OCCURED			
BY F	1 Natural 5 Pending 2 Accident Investigation	(MORRI, Omy, 1941)	INJUNI		RK? (ES 2 NO					
COMPLETED E	2 Accident 3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 26e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, Stete)						Route Number,			
PLE	29e. CERTIFIER (Check only (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner se stated.									
MO	(Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the tima, date end place, end due to the cause(s) end manner es stated.									
BE C	29b. SHINAYUHE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)									
2	30. NAME AND ADDRESS OF PERSON WHO COM	APLETED CAUSE OF DEATH	(ITEM 27) (Typ6, Pril	11)	D 0565	ō	▶ May 6), TAAD		
	Herbert H. Leighton			Street	, Oaklan	d, Marylan	d 21550			
	MAY 1 1 1995	32. REGISTRAR'S SIGNATULE	Hall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and four star death. Page 6 may be retained by the hospital or attending physician.

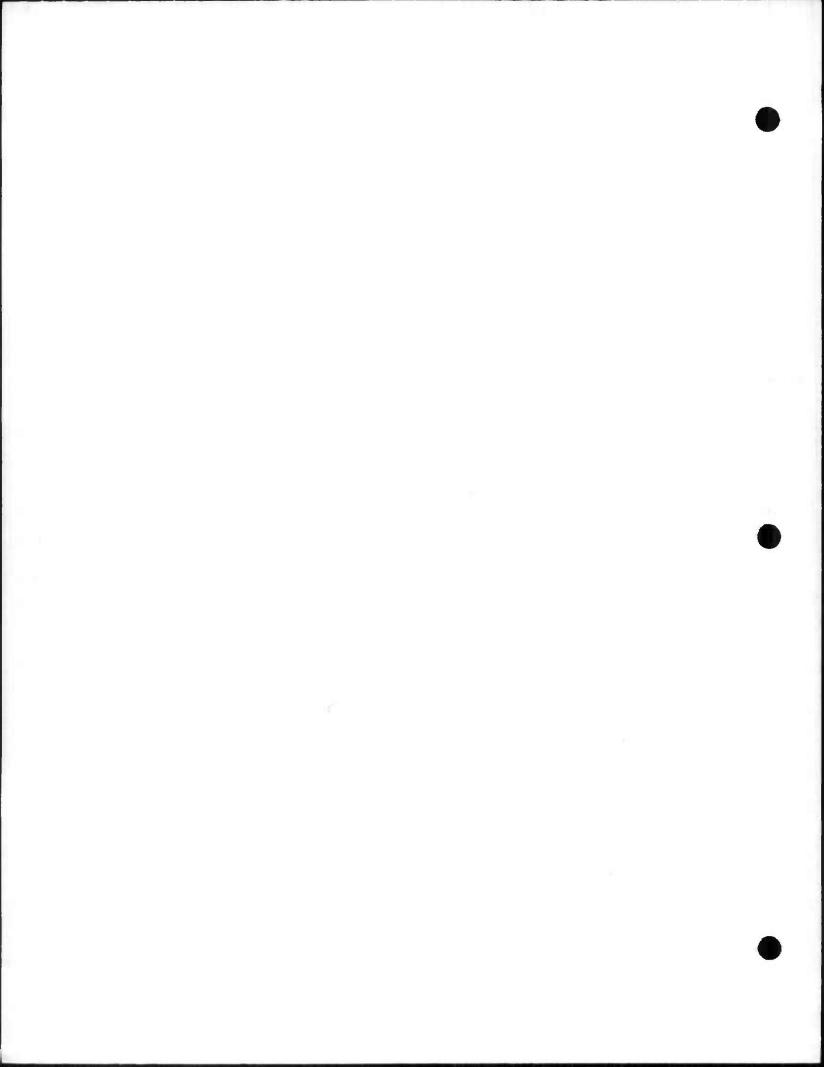
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First,	Allefella Lanti				IOAII		DLA	т.	HEG. NO.										
			-						- 1			YEAR	3. TIME OF DEATH							
	4. SOCIAL SECURITY NUMBER	MER	J.		KNOT	_					95		4:07 PM							
	4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (In yrs. la		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHP	LACE (State or Foreign							
	705-12-3274		1 🔀 M 2 🗆 F	93	YRS.	- Contrib	Lanie	noons		Sep 3, 190)1									
	9a. FACILITY NAME (If not in								ON OF DE		9c. COU	NTY OF DE	ATH							
E I	MEMORIAL H	OSPITA	L ,				BERI	AND			AL	LEGAN	Y							
DIRECTOR	RESIDENCE OF DEC	EDENT				1														
Ä.	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION				1	IOd. INSIDE CITY							
5	WV	Mine	ral		Ric	dgele	ey				3. TIME OF DEATH 995 8. SERTHPLACE (State or For Country) 901 8c. COUNTY OF DEATH ALLEGANY 10d. INSIDE CITY LIMITS? 1 YES 2 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian Black, Whita, atc. Specify: White 1900 100m, State, Zip Code) 26726 100cATION — City or Town, State 200cATION — City or Town, State									
7	10e. STREET AND NUMBER						101	. ZIP CODI	E		10g, CIT									
5	Route 2 Box	x 392						6753	1		-									
Ž		372	12 WAS DECEDEN	T EVER IN II C A	DMED	1 40														
		Married	FORCES? 1	YES 2	NO		If yes, sp	ecify_Cube	n, Mexican	, Puerto Rican, etc.)	or No-	14. RACE - Black,	- American Indian, White, atc.							
A	10e. STREET AND NUMBER ROUTE 2 BOX 392 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or NO—If yes, apecity Cuben, Mexican, Puerto Rican, etc.) 15. DECEDENT'S EDUCATION (Give kind of work done during most of working life. Do NOT use ratired.) 16. KIND OF BUSINESS/INDUSTRY 17. FATHER'S NAME (First, Middle, Last) Charles Knotts 18. MOTHER'S NAME (First, Middle, Maiden Surname) OLive (Carrico)																			
	Specify: White Specify: White Specify: White Specify: White Specify: White Specify: White Specify: Specify: White Specify: Specify: Specify: White Specify:																			
E																				
2																				
Ž				DX	rrer	TIIS	pect	_												
	, ,	.,,						- Telephone		,	Surname)									
BE								0	live	(Carrico)										
0				19	b. MAILING	ADDRESS	S (Street a	nd Number	or Rural Ro	oute Number, City or Town	, State, Zip	Code)								
-	Virginia W	olfe		1.	435 B	eaco	n St	reet	; Ke	vser, WV	2672	6								
	20. METHOD OF DISPOSITI	ON		20b. PLACE	AND DATE	OF DISPOS	SITION (Na						n, State							
	4 Donation 6 Other	n 3 ⊔ Hamo (Specify)	val from Stata	Rest	amatory or o	ther place)	rial	Gar	dens	05/07 Lav	ale.	MD								
1	21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	1 -100 0-		22.	NAME AN	D ADDRES	SS OF FAC	ILITY										
	▶ ○.	7	$\sqrt{ \alpha }$	11	1 6					eral Home										
	yon	ent	Nica	SUN	4	C	umbe	rlan	d, M	21502										
	23. PART I. Enter the di	seeses, or c	omplications the list only one cau	t coused the de	eth. Do	not enter	tha mo	de of dy	ing, such	ss cardiac or reaple	ratory ari	reat,	Approximate							
	IMMEDIATE CAUSE (Fin					3.0	illa.						Onset and Death							
	disesse or condition reaulting in death)	→ .	Ventr	Carlan	tib	nll	TITA	~ (a					A Day							
	rounting in death)		DUE TO	(OR AS A CONSE	QUENCE O	F):	70 00						1 22 18							
z			Ventro Cerov DUE TO	rary A	& to	211	0	A D OL	10				3 YARAL							
9	Sequentially list conditi if any, lesding to immed	ons,	DUE TO	OR AS CONSE	QUENCE OF	F): (g					1							
8	cause. Enter UNDERLY	NG																		
Ĕ	CAUSE (Disease or Injur that initiated events	y C	DUE TO	(OR AS A CONSE	QUENCE O	F):							+							
E	resulting in death) LAST	r L																		
B		-	•										+							
MEDICAL CERTIFICATION	PART II. Other significe	nt conditions	contributing to	death but not	resulting	n the un	derlying	cause g	lven in P	ert i. 24s. WAS AN			VERE AUTOPSY FINDINGS							
5	Old An	terio	wall	Physec	and	ial	L	fan	Colo:	PERFOR		c	MAILABLE PRIOR TO COMPLETION OF CAUSE							
				V				V	CATA	1 TES 2	NO		F DEATH?							
	DID TOBACCO US	SE CONTR	IRLITE TO CA	LICE OF DEA	TU VE	с П I	In E	LINIC	EDTAIN			'	☐ YES 2 XNO							
PHYSICIAN:	25. WAS CASE REFERRED TO		IBUTE TO CA		E OF DEAT			UNC	EKIAIN											
ᅙ	EXAMINER?	MEDICAL	HOSPITAL:	-		OTHER														
ĭ.	1 TYES 2 NO		1 Unpatient 2		1				sidence 6	☐ Other (Specify)										
급	27. MANNER OF DEATH Natural 5 1	Pending	28a. DATE OF (Month, Di		28b. TIM	E OF URY	28c. INJI WO	RK?	~	28d. DESCRIBE HOW IN	JURY OCC	CURED								
à		nvestigation		1		, м	1 🗌 Y		NO											
	3 Suicide 6 6	Could not be	28e. PLACE Of building,	F INJURY — At he etc. (Specify)	eme, ferm, s	street, fect	ory, office	•		28f. LOCATION (Street a: City or Town, State)	nd Number	or Rural Rou	ite Number,							
E I	4 Homicide	letermined							- 1	_	—									
COMPLETE	29a. CERTIFIER 1 CERTI	FYINQ PHYSIC	fAN: To the best of	my knowledge, de	eth occurre	d at the ti	me, data	and place	and due to	the cause(a) and man	nor on elek	ed.								
ž										me, data and place, and			and manners are related							
	29b. SIGNATURE AND TITLE					.,, 0					JUE IO M	- CEU-90(E) E	174 HERRIEF #8 SUITED.							
H	296. SIGNATURE AND TITLE	OF CENTIFIER					- 1	29c. LICE	NSE NUME	ER			fonth, Day, Year)							
2	1100	VVAC	- WIT)				D 1	17920		15	-5-1	795							
	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)														
	Dr. N. Sahe	ta, Me	morial H	lospital	, Cui	nber1	Land	, MD	215	02										
	31. DATE FILED (Month, Day.)	bar)	32. REGISTRA	R'S SIGNATURE							-									
	MAY 1 0	1995	Hen Maria	sertenta	4															
		-	/																	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Chour lifer death. Page 6 may be retained by the hospital or attending physician and completely filled in the life man be should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removed.

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1 - FOR STATE REGISTRAR

							10/11				- In	EG. NO.			
	1. OECEDENT'S NAME (First	, Middle, Last)									2. DATE OF E	DEATH	v	YEAR	3. TIME OF DEATH
	CARL FRI	EDERIC	K KIIFFNE	ER							MAY 9				07:53 A M
Ш	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (II	n yrs. lest	birthday)	IF UNDE	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF B				LACE (State or Foreign
1 1	217-10-4893	3	1 📮 M 2 🗆 F	0	9	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day		005	Country)	
	9a. FACILITY NAME (# not in	nstitution, give s		0	9		9h CIT	/ TOWN /	OR LOCAT	ION OF DE	JUNE 1	10 1		NTY OF DE	MARYLAND
Œ			,							.0 0. 02	2111		Bu. 000	WIT OF DE	AITI
DIRECTOR	MEMORIAL HOS	SPITAL.					CUM	BERL	AND_				ALL	EGANY	
	10a. STATE	10b. COUNT	Υ			10c, CIT	Y, TOWN	OR LOCAT	TION						10d, INSIDE CITY
#	MARYLAND	ALL	EGANY				CUMB	ERLA	ND					- 1	LIMITS?
1	10e, STREET AND NUMBER				_			T 40	r. ZIP COD						1 TYES 2 NO
A A			17 11 17												HAT COUNTRY?
	12107 BEDF	ORD RO							2150	2			U	S.A.	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN	U.S. ARI	MED	13.	WAS DEC	ENDENT (OF HISPAN	IC ORIGIN? (Sp	ecify Yea	or No-	14. RACE	— American Indian, White, stc.
BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y	AR OR DA	TES			1 YES	2)(NO	Specify	ri, Pulitio Mican	, atc.)		Specify	e '
	3 K widowed 4 Dive	жсец	<u> </u>												WHITE
	15. DEC (Specify onl	EDENT'S EDU	CATION completed)		18a, DE0	CEDENT'S	USUAL O	CCUPATIO	ON ast of worki	ina	16b, KINI	D OF BUS	INESS/INI	DUSTRY	
	Elementary/Secondary (0	-	College (1-4 or 5	-)	We.	Do NOT us	se retired.)								
₽	1.2 CELANESE CORP. OF AMERICA SILK/MANUF.														
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)			16. MOTHER'S NAME (First, Middle, Maid							, Maiden	Sumame)		
l w l	JOHN W. H	(IIFFN)	ER						HAI	NNAH	SCHAET	FER			
1 00	19a. INFORMANT'S NAME (1	Type/Print)			196	. MAILING	AOORES	S (Street a			loute Number, C		. State Zi	Code)	
일	LAVERNE O'N	JEAT													D 21502
	20a. METHOD OF DISPOSIT	27		201		NDDATE				N.E.	DATE				
	1 Nurial 2 Cremetic	on 3 🗆 Rem	oval from Stata	ceme	atery, crer	natory or o	ther place				1			City or Tow	
	4 ☐ Donation 6 ☐ Other		and di	<u> 1ST</u>	LUE	CES (995	CUM	BERL	AND M	ARYLAND
	21. SHAPATORE OF FOREIGN	L SERVICE LA	1111 3	1						SS OF FAC	FUNERA	T U)ME		
1 1	Nal	ed.	11 LOIND											TD 3641	DALL AND
\Box	23. PART I. Enter the d	iseeses, or o	complications the	t ceueed	the dec	eth. Do r	ot enter	the mo	de of dy	UK S	CREET (or ready	LKLAI	ND MAI	Approximate
i i	shock, or h	eert fellure.	List only one ceu	ве оп еа	ch line.				ac or ay	mg, soci	i de coluido	or reopii	otory st	1001,	Interval Between
1 1	IMMEDIATE CAUSE (Fir disesse or condition	nel													Onest and Death
	resulting in desth)	\rightarrow	MALIGN		-			A							2 MONTHS
			DUE TO	(OR AS A	CONSEC	WENCE O	F):								
Z	Sequentially list condit	lone C	b												
CERTIFICATION	if any, lesding to imme	diate	DUE TO	(OR AS A	CONSEQ	UENCE O	F):								
2	Cause. Enter UNDERLY		с												
	thet initieted events resulting in death) LAS		DUE TO	(OR AS A	CONSEO	UENCE O	F):								1
1 1 1	resulting in death) LAS	' (d												
	PART II. Other significa	nt condition	a contributing to	death bu	d not a	o altion	la éba su	a da alcela		alama Ini I	Date I as			Lauren	
EDICAL	TAIT II. Other eignines	THE CONTRICTOR	ie commodulig to	deeth bu	JI HOL PE	saurting.	in the ui	ideriyini	g cause	given in i	PBFT 1. 24a.	PERFOR	AUTOPSY MEO?		WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
ă											_ 10	YES 2	₩ NO		COMPLETION OF CAUSE OF DEATH?
ME															I _ YES 2 _ NO
ž	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	F DEAT	TH YE	S 🗆	NO [UNC	CERTAIN	IXIXI				
₹	25. WAS CASE REFERRED TO					E OF DEAT									
PHYSICIA	EXAMINER? 1 YES 2 NO		HOSPITAL:	FR/Outpu	tlant 3	□ DOA	OTHE		6 T B	a aldamaa	6 Other (Spe				
Ì	27. MANNER OF DEATH		28e. DATE OF		Tourn J	28b. TIM	_	26c. INJ		asidence	28d. DESCRIB		LINDY OC	CURED	
	37	Pending	(Month, D		- 1		URY	WO	RK7	7 110	zed. DEŞCHIB	E NOW IN	JUNT OC	CORED	
BĀ	I DOCTOOTIC	Investigation	200 01 405 0	E IN HARW	41.1.	0.75		_		JNO					
8	3 Suicide 8	Could not be determined	28a. PLACE O building,	atc. (Speci	- At hon	ne, term, s	street, fac	lory, offici	•	- 1	28f, LOCATION City or Tox	N (Street a vn, State)	nd Number	or Rural Ro	ute Number,
E															
4	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the best of	my knowle	edge, des	th occum	ed at the t	lme, data	and place	, and dua	to the cause(a)	and men	ner sa sta	ted.	
COMPLET															and menner as stated.
	29b. SIGNATURE AND TITLE									ENSE NUM		-			Month, Day, Year)
88	7	91	1-strue	_							oen.		A A	c SIGNED (MOTHIN, Day, Teler)
ဥ	30. NAME AND ADDRESS OF	PERSON WAL	O COMPLETED CALL	E OF OF	TH //YEA	270 (7	Delet*		D332	280			- 10	ay 9	, 1775
	DR. SUNIL K	GUP.						BERL	AND 1	MARYI	LAND 2	21502	2	V	
	31. DATE FILED (MAA)	1019	32 REGISTRA	R'S SIGNA	TURE	dalle									

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMEN	T OF HEALTH AND MENTAL H	IYGIENE
CERTIFICAT	F OF DEATH	DEC NO

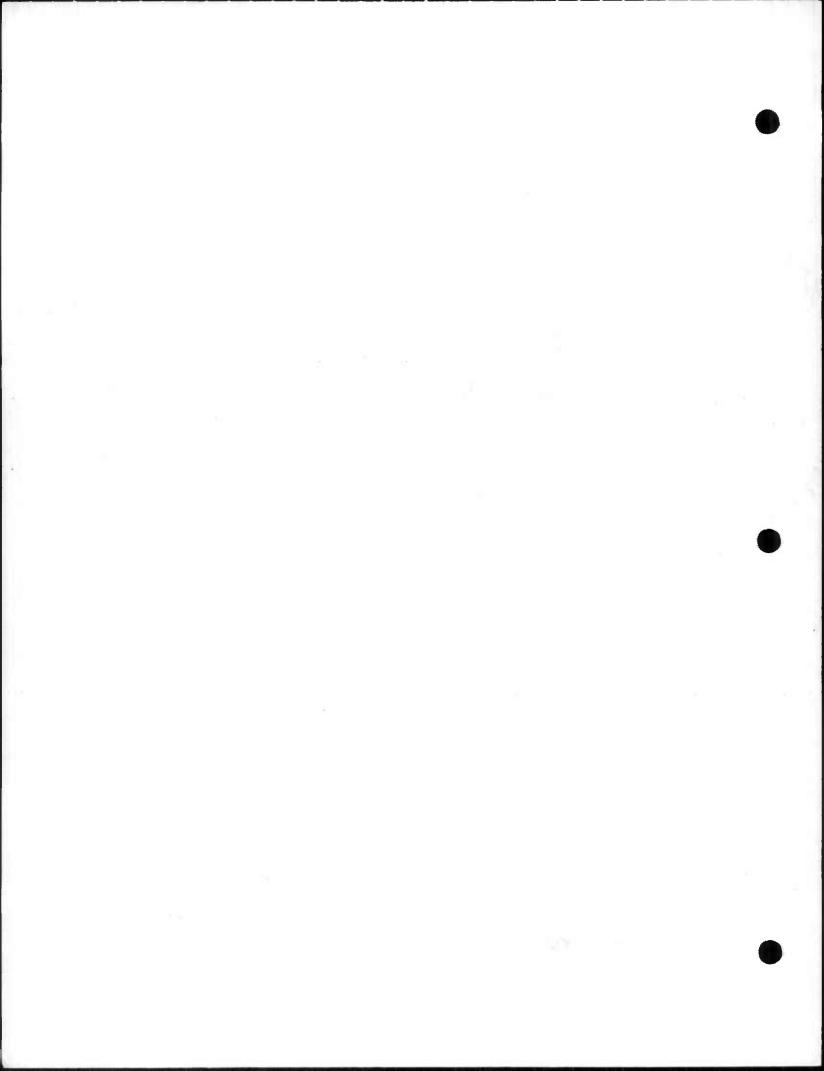
	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF DEA	TH	
	BRIAN E.	LAWSON				MAY			YEAR	1945	рм	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BURTH	- 17	6. BIRTH	PLACE (State or F		
	213-86-8704	1 M 2 □ F]	8 YRS.	MONTHS DAYS	HOURS MIN.	Aug	. 21,19	76	Countr	aryland	1	
~	9a. FACILITY NAME (If not institution, give s				OR LOCATION OF I	DEATH			NTY OF D			
<u> </u>	SUBURBAN HOSPI	TAL		BETHE	ESDA			MON	'I'GO	MERY		
E C	10a. STATE 10b. COUNTY	Υ	10c. CIT	r, TOWN OR LOC	ATION				1	10d. INSIDE CIT	Y	
DIRECTOR	Maryland 1	Montgomery		Damaso	eus					LIMITS?		
4	10e. STREET AND NUMBER				Of. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?		
FUNERAL	10148 Shelldral	ke Circle			20872	2		Uni	ted	States		
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED		CENDENT OF HISPA				14. BACE	- American Indi	ien,	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			pecify Cuban, Mexic S 2 NO Spec		Hican, atc.)		Speck			
	15. DECEDENT'S EDU	CATION								Mite		
COMPLETED	(Specify only highest grade	completed)	18e. DECEDENT'S (Give kind of v life. Do NOT us	rork done during n	ION nost of working	168	. KIND OF BUS	INESS/IND	USTRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Maintena	ŕ	ton		A == ====	t				
ŏ	17. FATHER'S NAME (First, Middle, Last)		TIGETH OF THE	ince 101		AME (First.	Apar					
BEC	Alfred Euger	ne Lawson			Sh	eri	ME (First, Middle, Maldon Surname) eri Mitchell					
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural				Code)			
일	Sheri Mitchell I	awson	101 5	helldra	ke Circl	e, Da	amascu	s, Mo	1. 20	872		
į	20a, METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Rame	ovel from State	PLACE AND DATE	F DISPOSITION (lame of	DAT	E 20c. LO	CATION -	City or To	wn, State		
	4 Donation 5 Other (Specify)		Upper Se	neca Ba	ptist 5/	13/9	5 Ce	edar	Grov	e, Md.		
1	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	,	22. NAME /	n L. Mol	ACILITY ASTAD	rth. P	Α				
	Ollen Z.	Wolesun	the	261	Ol Ridge	Rd.	. Damaso	ns.N	rd. 2	0872		
	23. PART I. Enter the diseases, or cahock, or heert failure. IMMEDIATE CAUSE (Final	complications that cause List only one cause on a	d the deeth. Do neach line.	ot enter the m	ode of dying, su	ch as can	dlec or respi	ratory arr	eat,	Approxim Interval B Onset and	etween	
	disease or condition resulting in death)	DUE TO (OR AS	ple I,	njurie	5							
z			· ·	<i>'</i> U						j		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS /	CONSEQUENCE OF):						1		
<u> </u>	CAUSE (Disease or injury	C										
<u> </u>	that initiated events reaulting in death) LAST	DUE TO (OR AS /	CONSEQUENCE OF):								
# I		d								ļ		
AL	PART II. Other significant condition	s contributing to death b	out not resulting i	n the underlyi	ng cause given in	Part i.	24a, WAS AN		24b.	WERE AUTOPSY F		
							PERFOR			AVAILABLE PRIOR COMPLETION OF (OF DEATH?		
ME										1 K YES 2	NO	
ž I	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	F DEATH YE	S I NO	L UNCERTAI	N 🗆						
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one OTHER:)							
2	1 XYES 2 NO	1 Inpatient 2 ER/Out		4 - Nursing Ho	me 5 - Realdenca							
BY PHYSICIAN: MEDIC	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	JRY W	JURY AT ORK?	1	SCRIBE HOW I					
- 18	2 Accident Investigation	5-9-95	/745 — At home, farm, s		YES 2 THO		torvehi					
3	3 Suicide 6 Could not be 4 Homicide detarmined	building, etc. (Spe 5 treet	cffy)	treet, factory, om	CIII	City	ATION (Street e or Yown, State)	Brink	Rd -	R+27		
9 1	29a. CERTIFIER							o h	4			
COMPLEIED		CIAN: To the best of my know R: On the bests of examination								m Vancous es	2001/	
	29b. SIGNATURE AND TITLE OF CERTIFIER		Transport Investigation	t, in my opinion,			end place, and				tated.	
	1) -	1. Chut	.0		29c. LICENSE NU					(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHY	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print)	0.C.N	1.E		MA	Y 1	1,1995		
	6	/			ot Da	ltim	ore 1	Marri	lan	a 2120	,	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE O	II SLIE	et, Ba	LLIII	OTE,	чат у	Tall	4 2120	-	
1	MAY 1 5 199	5 Julia d'auc	yor Tarbell	1								

et.

BALTIMORE, MARYLAND 21215-0020 Phours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN. THE IN- requires that the death certificate be executed within 24 TO THE FUNERAL DIRECTOR. After this certificial the someted by the attending physician and completely fit. DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

			CKIII	ICATE	JF DEATH	REG. NO									
		1101306 67	NO	5				3. TIME OF DEATH							
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les	st birthday)	IF UNDER 1 YE		7. DATE OF BIRTH	8	BIRTHPLACE (State or Foreign							
_		213-01-5872 ¹ X M 2 D F 90	YRS.	MONTHS DA	YS HOURS MIN.	July 4,1	004	Country)							
hour		9s. FACILITY NAME (If not institution, give street and number)		9b. CITY, TO	WN OR LOCATION OF D			Maryland Y OF DEATH							
ure ountal-transit permit. Pages 1, 2, 3 should	DIRECTOR	Shady Grove Adventist Hosp	ita	F	Rockville	9		ntgomery							
es l	EC	10a. STATE 10b. COUNTY	10c, CIT	Y, TOWN OR LO	OCATION			10d. INSIDE CITY							
nt. Pag		Maryland Montgomery		Damaso				LIMITS?							
srt per	FUNERAL	10e. STREET AND NUMBER 27513 Ridge Road			101. ZIP CODE 20872			I · S · A ·							
-tran	N.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR	MED	12 140.0	DECEMBENT OF HICEA	NIC ORIGIN? (Specify Yes	1 10								
DOULA		1 Never Married 2 Married FORCES? 1 YES 2 X		If yes	, specify Cuban, Mexico	in, Puerto Ricen, etc.)	1 OF NO 14	4. RACE — American Indian, Black, White, etc.							
an and	ВУ	3 XWidowed 4 Divorced IF YES, GIVE WAR OR DATES		1 🗆	YES 2 NO Specif	y:		Specify: White							
S	0.	15. DECEDENT'S EDUCATION 16a. DF	CEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	CINECO (IND. II								
So	E	(Specify only highest grade completed) (G	ive kind of v	work done during	g most of working	100. KIND OF BU	SINE SS/INDUS	JIRY							
2	7			epair		Au	tomob	oile							
onco.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)	Res	torat											
0 0						ME (First, Middle, Maiden									
9 P	BE	George Long				e Rebecc									
be notified	2	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
2 2		5. Dalion hong 20020 Kemptown Road, Damascus, Md. 20													
2		20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)													
must		4 Donation 5 Other (Specify) Montgomery Methodist 5/12 Damascus, Marylar													
ě		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
or removal. medical examiner		Olini L. Molesnoth	,					Funeral Home							
or removal.		23. PART I. Enter the diseases, or complications that caused the de	ath. Do n	ot enter the	mode of dying, auc	h as cardisc or respi	ratory arres	et, Approximate							
		IMMEDIATE CAUSE (Final													
cremation,		disease or condition													
d, crema	1	disease or condition a. CARNIO 9 EWIZ SHOCK DUE TO (OR AS A CONSEQUENCE OF):													
- a	_	Antic ste	641.00					2/1000							
to bu	Ó	Sequentially list conditions,						sycals							
traumatic	A	if any, leading to immediate			and We			5-Ch11-							
Health and Mental Hygiene prior IWS any injury, or other trau	CERTIFICATION	CAUSE (Disease or injury	DIENCE OF	www.	40 Ker rus			gais							
9 4	Ē	that initiated events resulting in death) LAST	NOCITOR OF	,.	0										
tal Hy	與														
th and Menta any injury,		PART ii. Other significant conditions contributing to deeth but not re	esuiting i	n the underl	vina ceuse alven in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS							
and w	EDICAL	FAIR COM C ROAD FA'													
realth Ars a			1			1 🗆 YES 2	NO	OF DEATH?							
Show	Σ							1 TYES 2 NO							
F 23	ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	TH YE	S NO	UNCERTAIL	4 D									
State Dept. Hern 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLAC	E OF DEAT	H (Check only o	one)										
the Sta	S	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3	□ DOA	OTHER:	Home 5 - Residence	6 Other (Specify)									
	ξ	27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIM	E OF 28c.	INJURY AT	28d. DESCRIBE HOW II	NJURY OCCUF	RED							
marked,		1 Netural 5 Pending (Month, Day, Year)	INJ	URY 1	WORK? YES 2 NO										
r deat	D BY	3 Suicide 28a. PLACE OF INJURY — At ho	me, term, a	treet, factory, o	office	281. LOCATION (Street a	and Number or	Rural Route Number							
after 28	ш	4 Homicide determined building, etc. (Specify)				City or Town, State)		The state of the s							
S E	Щ	29a. CERTIFIER		_											
12 H	COMPL	(Check only TOX) CERTIFYING PHYSICIAN: To the best of my knowledge, de													
E H	ŏ I	2 MEDICAL EXAMINER: On the basis of examination and/or i	nveatigation	n, in my opinio	n, death occured at the	time, data and place, an	d due to the c	ause(s) and manner as stated.							
filed within 72 hours after PORTANT: If item 28 is		296. SIGNATURE AND TITLE OF CHATTERER			29c. LICENSE NUI	ABER	29d. DATE S	IGNED (Month, Day, Year)							
be filed within	BE	/ your oder			02139	0									
Δ=	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	1 27) (Type.	Print)	/			49,1995							
		RAYMOND BASS M.D 3941 FERR			WHEATO	NHO Z	2090	6							
- 1		31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE		١											
		MAY 1 0 1995 Julia Savileon	endall												



REGISTRAR		CERTIFIC	CATE OF D	DEATH		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)	T.				2. DATE OF			3. TIME OF DEATH
RODDETTA	ONES	LEWIS			MAY	06,19	995 YEAR	13:54 P
4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF			HPLACE (State or Foreign
578-34-8987	1 M 2 F			IOURS MIN.	(Month, D	20,191	Coun	rginia
9a. FACILITY NAME (If not institution, give	treet and guarber)		9b. CITY, TOWN OR	LOCATION OF DE	EATH	9	c. COUNTY OF	
9a. FACILITY NAME (if pot institution, give in the second of the second	E AVE.		Garrett	Park		1	MONTGO	MERY
10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCATIO	N				10d. INSIDE CITY
	Montgomery		Garrett	Park				LIMITS?
100. STREET AND NUMBER 4424 Strathmore A 11. MARITAL STATUS			10f. Z	20896				WHAT COUNTRY?
11. MARITAL STATUS							Jnited	
1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES 2 NO	If yes, speci	IDENT OF HISPAN Ify Cuben, Mexical XXNO Specify	n, Puerto Rica		No— 14. RAC Blac Spen	E — American Indian, sk, White, etc. chy:
15. DECEDENT'S EDU		16a. DECEDENT'S U	SUAL OCCUPATION		16b, Ki	ND OF BUSINE	ESS/INDUSTRY	WILLCO
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2 17. FATHER'S NAME (First, Middle, Lest)	College (1-4 or 5+)	(Give kind of wo	rk done during most o	of working	1000000			
12		Bus D	river			Schoo	2]	
17. FATHER'S NAME (First, Middle, Last)				IS. MOTHER'S NAI	ME /First Mick			
	able Cal	vin Jones					attie	
19e. INFORMANT'S NAME (Type/Print)			DDRESS (Street and				0.1.	
Sandra L. Carter			nham Road			Maryl	land 2	0851
20a, METHOD OF DISPOSITION 1 □ Burlat 2X□ Cremation 3 □ Rem	oval from State	206. PLACE AND DATE OF Cometery, crematory or oth Montgomery	DISPOSITION (Name	l'1. 199	5 DATE	1	ION — City or T	
4 Donation 6 Other (Specify)	CENCEE	Montgomery	Cremato	riúm, I	nc.	Bethe	esda, M	aryland
Muidele 9	Kutto	M00348	Home/Rockvi	ockville lle, Mai	e, Inc ryland	ert A. ., 300 l 2085	Pumph W. Mo 50-2805	rey Funeral ntgomery Av
	DUE TO (OR	AS A CONSEQUENCE OF)		rascule	u di	rease		Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR	AS A CONSEQUENCE OF)						
PART II. Other significant condition	na contributing to dea	ith but not reculting in	the underlying c	ceuse given in		e. WAS AN AUT PERFORMEI	D?	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONT	RIBLITE TO CALIS	E OF DEATH YES	ПОП	LINICEDTAIN				1 PYES 2 NO
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X YES 2 NO 27. MANNER OF DEATH	KIDOTE TO CAOS	26. PLACE OF DEATH		ONCERIAIN	4 11			
EXAMINER?	HOSPITAL:		OTHER:	. 37				
27. MANNER OF DEATH	28a. DATE OF INJ		OF 28c, INJUR					
	(Month, Day, Y	ear) INJU	RY WORK		28G. DEŞCH	IBE HOW INJU	RY OCCURED	
2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF IN.	JURY At home, farm, str			28f. LOCATIO	ON (Street and	Number or Rural	Brutta Number
4 Homicide 6 Could not be determined	building, etc.	(Specify)	,		City or T	own, State)	Training of Florer	Todie Promod,
		knowledge, death occurred						a) and manner se stated
A CONTROL AND THE OF CENTIFIE	right MI)	2	9c. LICENSE NUM	IBER			(Month, Day, Ybar)
30. NAME AND ADDRESS OF PERSON WH			Print)	OCME			MAY 0	7,1995
DONALD G WRIG								
DONIALIS G CONTA	IVIU	111 Day	n Strag	ot Ra	1 + ima	ro L	C I were a	nd 21201

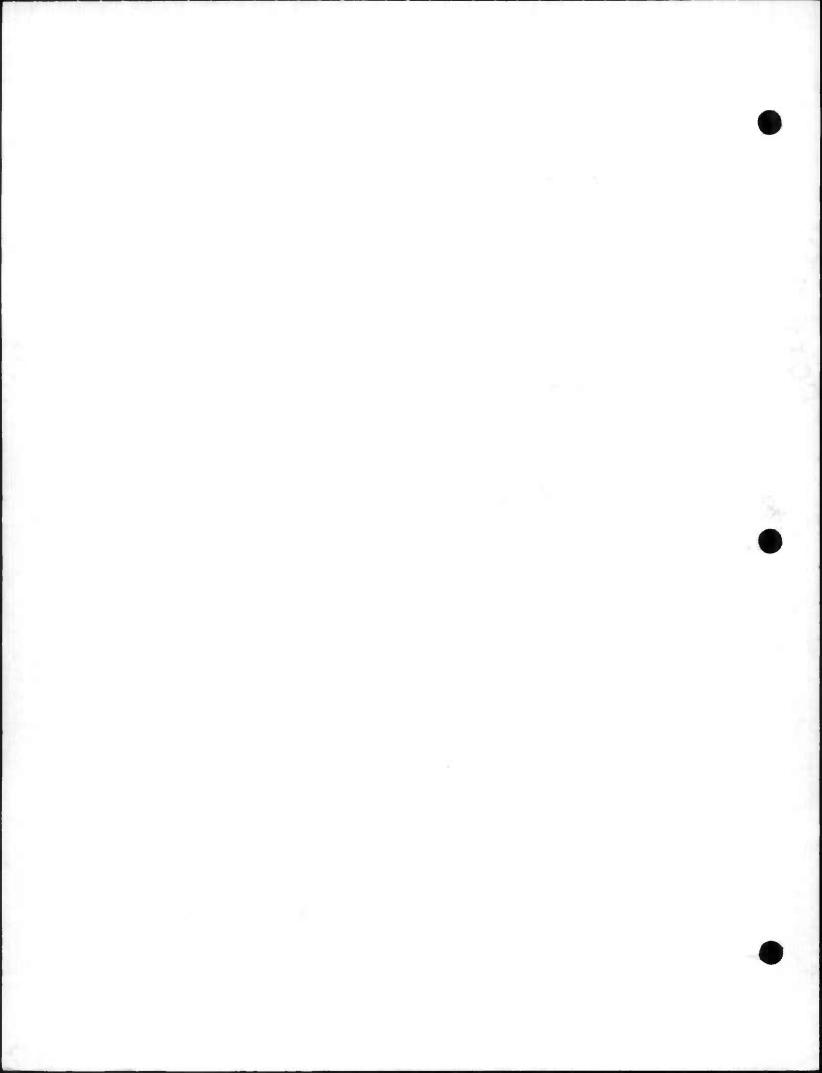
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

SBALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flowers after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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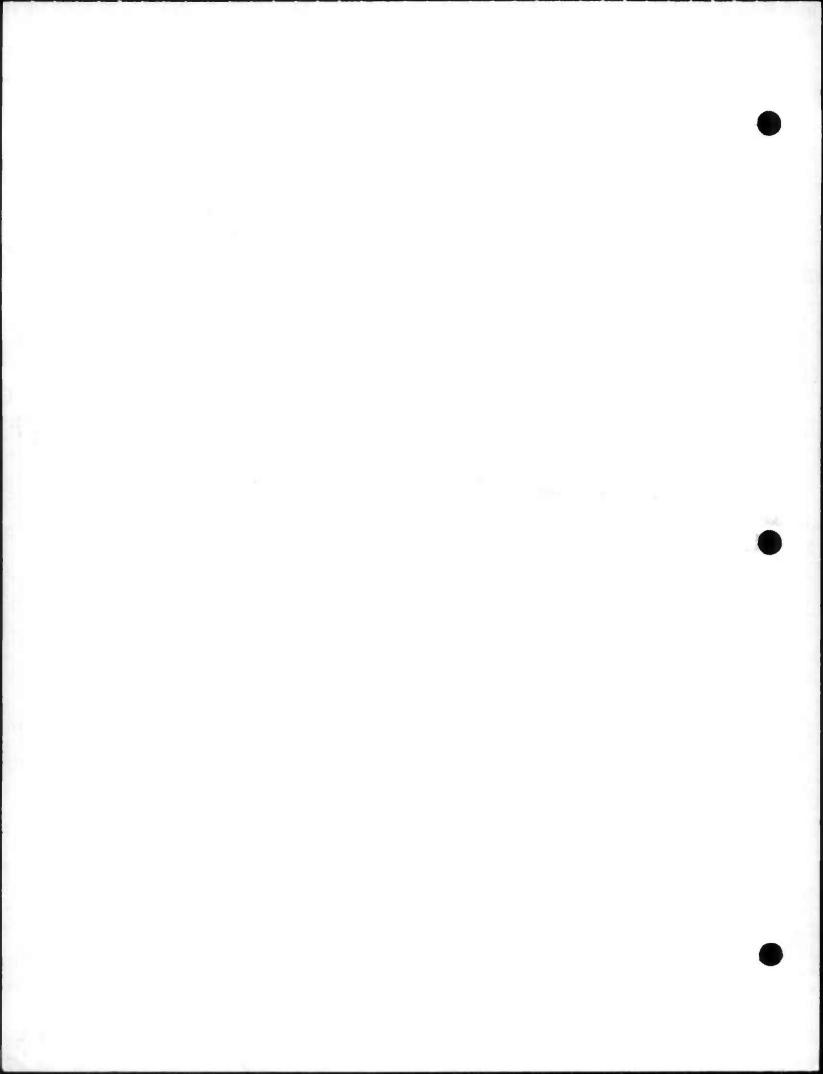
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

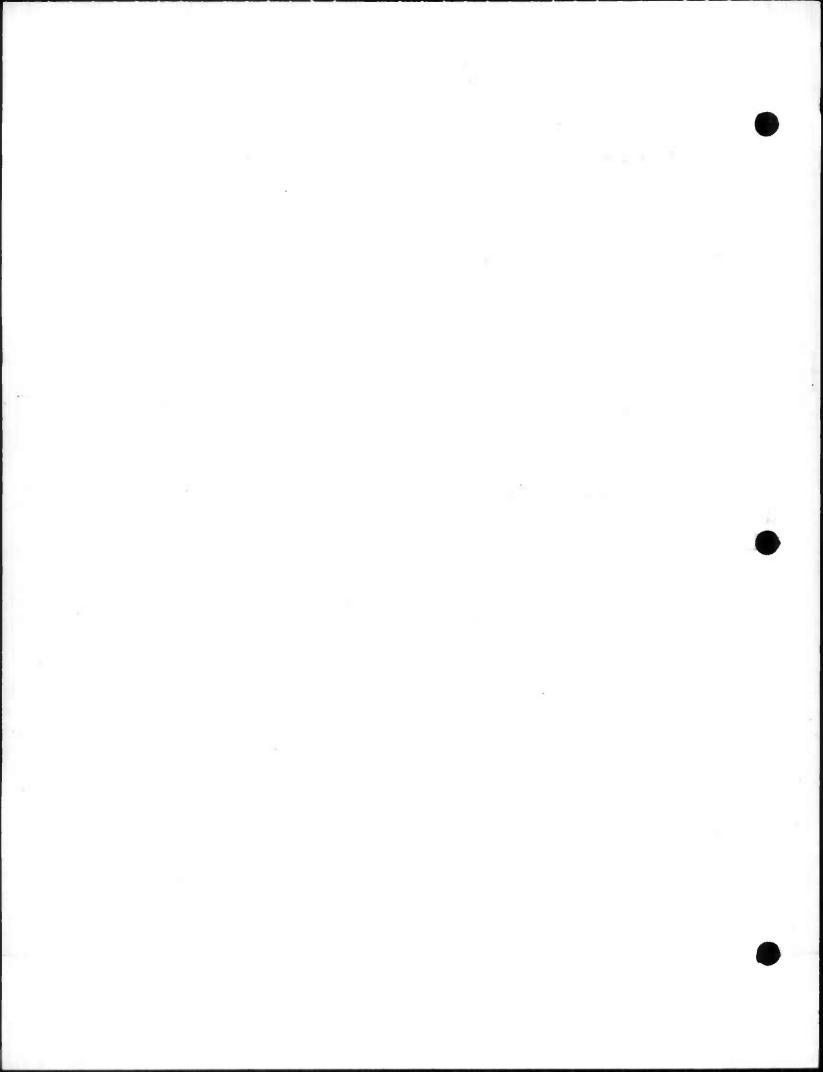
	REGISTRAR		CERTIF	CATE O	FDEATH		REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. TIME OF DEATH				
	FLORENCE	E LAKOFF				Мау	4, 19	95	6:30A M				
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH / al		IPLACE (State or Foreign				
	087-05-0479	1 D M 2 D X 80	YRS.	MONTHS DAYS	HOURS MIN.	Marci	ay, Year)	Count	w York				
	9e. FACILITY NAME (If not institution, give str			9h CITY TOWN	OR LOCATION OF D			OUNTY OF D					
œ			- 1										
6	Holy Cross Host	oltal		SIIVE	er Sprin	19	1	donto	omery				
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOC	ATION	4 .			10d, INSIDE CITY				
1 8	Md. Monto	gomery		Ret h	esdh Be	therde	2		LIMITS?				
	10e, STREET AND NUMBER	Journal J			Of, ZIP CODE				1 YES 2 NO				
FUNERAL	10910 Old Geo	orgeTown Rd	,	0	20814		10g. 1	US					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	J.S. ARMED		CENDENT OF HISPA				E — American Indian,				
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE			specific Cuben, Mexic S 2 NO Specific		in, etc.)	Speci	k, White, etc.				
TED	15. DECEDENT'S EDUC	ATION 1 completed)	6a. DECEDENT'S	USUAL OCCUPAT	TION nost of working	16b, Kil	NO OF BUSINESS	INDUSTRY					
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ College Labor Law Governmen												
S	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname)												
ш	Samuel Lakoffsky Anna												
00	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
5	Matthew Abrams 7317 Cliff Pine Dr. Gaithersburg, Md.208												
	29a METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of												
	11-13 Buriel 2 Cremation 3 Removal from State Cempatery, crematory-or other place)												
1 1	21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
	Edward Sagel Funeral Direction 1091 Rockville Pike RockvilleMfd208												
Щ	cleet			109	1 Rockv	ille	Pike R	ockv					
	23. PART I. Enter the diseases, or co	omplications that caused to list only one cause on each	he deeth. Do n	ot enter the m	ode of dylng, suc	ch ss cerdied	or respiratory	arrest,	Approximete Interval Bstween				
	IMMEDIATE CAUSE (Fine)												
	disesse or condition sesuiting in death) a. SEPS15												
		DUE TO (OR AS A C							MORE THEN				
z		<i>H</i>	LZHIEN	IER DI	SEASE				17				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C											
8	CAUSE (Disesse or Injury												
	that initiated eventa	DUE TO (OR AS A C	ONSEQUENCE OF):									
돈	resulting in death) LAST												
	DART II Other classificant and dislan-		The state of the state of										
DICAL	PART II. Other significant conditions	contributing to deeth but	not resulting in	n the underlyl	ng ceuse given in	Part I. 24	e. WAS AN AUTOP! PERFORMED?	SY 24b.	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ă						1	YES 2 NO		COMPLETION OF CAUSE OF DEATH?				
M									1 YES 2 NO				
ż	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YE	S I NO	UNCERTAI	N 🗆							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEAT)								
Sic	The state of the s	HOSPITAL:	ent 3 🗆 DOA	OTHER: 4 \(\text{Nursing Ho} \)	me 5 🗆 Residence	6 Other (Se	pec/fv)						
三	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME	OF 28c, IP	JURY AT		BE HOW INJURY	OCCURED					
ВУ Г	1 Natural 5 Pending	(Month, Day, Year)	INJU		ORK? YES 2 NO								
	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY -	At home, term, st	treet, factory, off	ce	26f. LOCATIO	N (Street and Num	ber or Rural F	Route Number,				
E I	4 Homicide determined	building, etc. (Specify)	,			City or To	own, State)						
9	29e. CERTIFIER	IAN. T. de A. de de de de de de de de de de de de de	un restricted				- Seminorary	-					
COMPLETED		IAN: To the best of my knowled: On the basic of examination e							and many in Wall				
8			the basis of examination end/or investigation, in my opinion, death occured at the ti					The couse(e	g end menner as stated,				
BE	296. SIGNATURE AND TITLE OF CERTIFIER	0			29c. LICENSE NUI	MBER	29d. 0	ATE SIGNED	(Month, Day, Year)				
	Ccham Bholone				12474	70.		05/1	14/95				
0													
10	30. NAME AND ADDRESS OF PERSON WHO			. /	7	0	11.	1					
10	1	QUID 470 -	Rondo	. /	pad 1	Rozwi	lk. 20	1852					



Amended 19a., 5/12/95, G.F., Montgomery Co.

1. STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

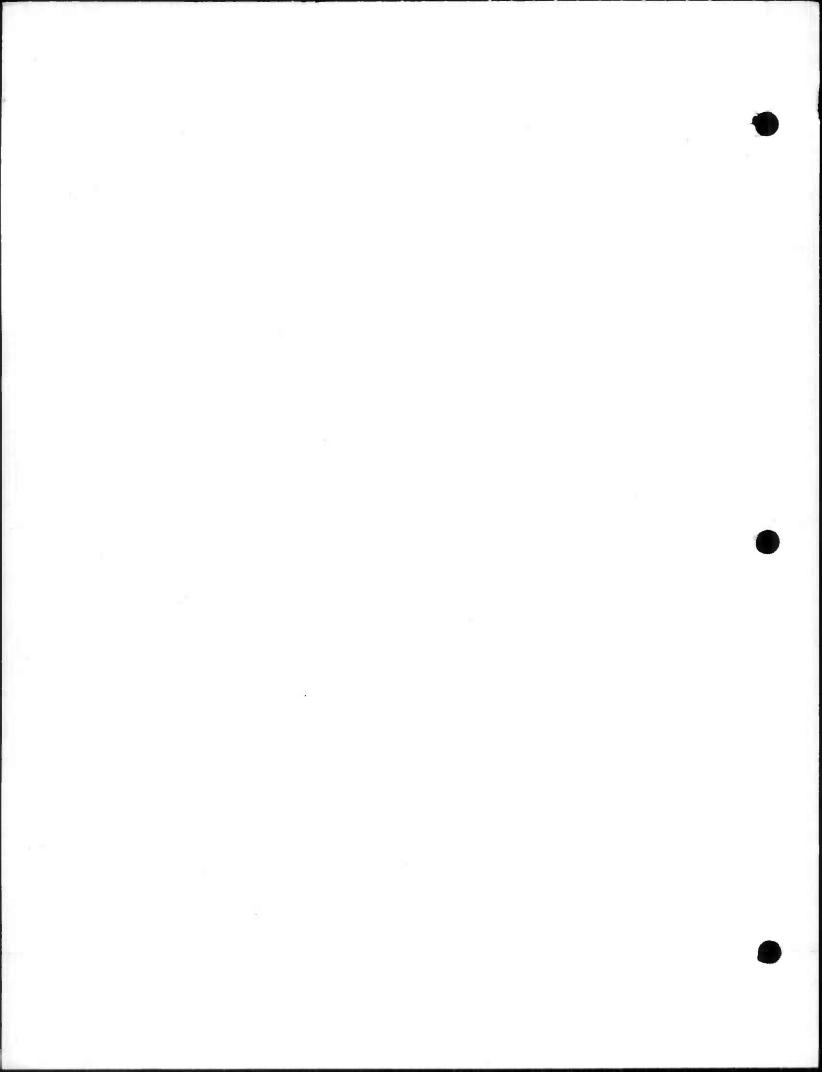
	REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY Y	3. TIME OF DEATH
	Marie	Louise Loy	i.		i	May 4, 19		4:00 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
	577-34-0739	1 M 2 💢 F	65 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Aug. 14,1		Country)
1	9a. FACILITY NAME (If not institution, give a	street and number)		OF CITY TOWN C	R LOCATION OF DEA			ennsylvania
Œ	18120 Chalet Dri					NI PI	1	Y OF DEATH
6	RESIDENCE OF DECEDENT	ve, #102		Germa	ntown		Mont	gomery
DIRECTOR	10a. STATE 10b. COUNT	Υ	10c. CITY	TOWN OR LOCAT	ION			10d. INSIDE CITY
E	Maryland Mon	ntgomery		German	town			LIMITS?
	10e. STREET AND NUMBER	1090027			ZIP CODE		T	1 YES 2 NO
A	18120 Chalet Dri	#102		100	111 -11 1121			N OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS				20874			d States
교	1 Never Married 2 Married	12. WAS DECEDENT EVEN FORCES? 1 1	ES 2 NO	13. WAS DEC	ENDENT OF HISPANI scify Cuban, Maxican	C ORIGIN? (Specify Yes, Puerto Ricen, etc.)	or No- 14	I. RACE — American Indian, Black, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES	1 TYES	2 XNO Specify:			Specify:
	15. DECEDENT'S EDU	CATION						White
	(Specify only highest grade	completed)	16a. DECEDENT'S L (Give kind of we life. Do NOT use	ork done durina mo:	on st of working	16b, KIND OF BU	SINESS/INDUS	TRY
ا څ	Elementary/Secondary (0-12)	College (1-4 or 5+)				,,		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)	4	Nur	se			spital	
8	, , , , , , , , , , , , , , , , , , , ,	J. Lamb				E (First, Middle, Maiden		
BE		U. Laitb				e L. Reila		
9	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Tow		
	Raymond D. Loyd		18120	Chalet I	rive, #1	02, German	nton,	MD 20874
	20a. METHOD OF DISPOSITION 1 № Burlal 2 □ Cremation 3 □ Rem	oval from State	20b. PLACE AND DATE OF cometery, crematory or oth	F DISPOSITION (No	Tay 7 19	DATE 20c. LO	CATION - City	y or Town, Stata
	4 Donation 6 Other (Specify)		cemetery, crematory or oth Gate of Hea	aven Cer	netery	Sil	ver Sp	ring Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME AN	D ADDRESS OF FAC	Nobert	A. Pu	mphrey Funeral Montgomery Ave
	Thickele 4	Sutta	M00348	ROCKVI	lile, Mar	yrand 208	350-28	05
	23. PART i. Enter the diseases, or shock, or heart failure.	complications that cau	ned the death. Do no	ot enter the mo	de of dying, auch	as cerdiec or respi	ratory arrest	
	IMMEDIATE CAUSE (Final	List Officione Cease 0	n each line.					interval Between Onset and Death
j	diagona or condition	Renal Fa	ilure					3 years
- 1	readiting in death)		AS A CONSEQUENCE OF)	:				J years
z		Diabetes	Mellitus					22 years
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF)	:				7
3	CAUSE (Disease or Injury	С						
田川	that initiated events	DUE TO (OR /	AS A CONSEQUENCE OF)	:				
6	reaulting in death) LAST	d						
	PART II. Other algnificant condition	a contributing to deal	th but not consisting to	the rendering	anne shire to B			
MEDICAL	Sarcoidosis	- contributing to deal	or not readiling in	i the underlying	ceuse given in P	art I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă						1 YES 2	X NO	COMPLETION OF CAUSE OF DEATH?
ž	Essential Hyper							1 TES 2 K NO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YES	ON O	UNCERTAIN			
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH					
S	1X YES 2 □ NO	1 Inpatient 2 ER/		OTHER: 4 Nursing Home	5 M Residence 6	☐ Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJU (Month, Day, Ye.		OF 28c. INJU		28d. DESCRIBE HOW I	YJURY OCCUR	NED
BY	Netural 5 Pending 2 Accident Investigation	(month, bay, to	indo		ES 2 NO			
- 10	3 Suicide 6 Could not be	28e. PLACE OF INJ building, atc. (URY — Al homa, farm, ati	rant, factory, office		281. LOCATION (Street a	nd Number or i	Rural Route Number,
COMPLETED	4 Homicide detarmined	bulling, atc. (эрвску)			City or Town, State)		
1 1	29a. CERTIFIER 1 X CERTIFYING PHYSI	CIAN: To the best of my k	nowledge death occurred	et the time date	and place and due to			
١١١								ause(a) and manner as stated.
8	296. SIGNATURE AND TITLE OF CERTIFIE							
H H	1	\n \n			29c. LICENSE NUMB	DER	29d. DATE SI	IGNED (Month, Day, Year)
۵,	30. NAME AND ADDRESS OF PERSON WH	Ory V	2		11308	74	19	-4-7
1		/ / /			71 7	/		
V	James F. McMurry,			mocracy	Blvd., B	ethesda,	MD 208	17
	THE PILED (Month, Day, Year)	32. REGISTRAR'S S						
	MAY 08 1995	Julia Stavile	on Roll					
		11	- WILLE					



BALTIMORE, MARYLAND 21215-0020	new hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should th the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760 & BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5s hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

$\overline{}$						10711	- 91				HEG. NO.					
	1. DECEDENT'S NAME (First				2					2. DATE O	F DEATH DA	γ.	YEAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER		las Thom			_					9, 19	95		9:15 A M		
	108-42-1360		5. SEX	6. AGE (In yr.	s. last birthday)	MONTHS	R I YEAR	HOURS	MIN.		Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign y)		
	9a. FACILITY NAME (If not in		.,	40	THO.	21 21				April	3,19	_		York		
œ			,			9b. CIT		OR LOCATI		EATH			INTY OF D			
유	13 Wetherfi		urt				Ъ.	otoma	ac			1	Montg	omery		
DIRECTOR	10a. STATE	10b. COUNTY			10c, Cl	ry, town	OR LOCA	TION						10d. INSIDE CITY		
	Maryland	Mont	gomery				P	otoma	ac					LIMITS?		
M	10s. STREET AND NUMBER						10	f. ZIP COD	E			10g. CI1	TIZEN OF V	VHAT COUNTRY?		
빌	13 Wetherfi	eld Co	urt					2	20854	1		Uni	ited	States		
FUNERAL	11. MARITAL STATUS 1 Never Married 2XX		12. WAS DECEDEN FORCES? 1			13.	WAS DE	CENDENT (OF HISPAN	IIC ORIGIN?	Specify Yea	or No-	14. RACE	— American Indian, t, White, stc.		
ВУ	3 Widowed 4 Dive		IF YES, GIVE W				1 YES	2 X NO	Spec#)	y:	ant, accep		Speci	ty:		
	15. DEC	EDENT'S EDUC	CATION	164	. DECEDENT'S	I I SI IAI	CCUBATI	ON		1 405 10				White		
		y highest grade			(Give kind of life. Do NOT u	work done	during m	ost of working	ng	16b. KIND OF BUSINESS/INDUSTRY						
F	was .		5+	'	Banker						- 1					
COMPLETED	17. FATHER'S NAME (First, M	iddle, Last)				16. MOT	HER'S NA	ME (First, Mic	Bank							
BE 0	Thoma	s Dani	el Ledwi	th		16. MOTHER'S NAME (First, Middle, Maiden Surnam Ruth Thompson						on				
TO B	19a. INFORMANT'S NAME (7		ILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
٦	Barbara A.	13 We	ther	fiel	d Cot	ırt,	Potom	nac, M	lary	land	20854					
	20a. METHOD OF DISPOSIT: 1 ☑ Burlel 2 ☐ Crematic	CE AND DATE	OF DISPO	SITION (N	amq 03.	1995	OATE	20c. LOC	ATION -	City or To	wn, Stata					
	4 Donation 6 Other	(Specify)		St.	Gabri	el's	Cem	etery	7		Poto	mac	, Mar	yland		
	21. SIGNATURE OF FUNERA		22.	NAME A	ND ADORE	SS OF FA	CUTYROL	ert A	. Pı	ımphr	ey Funeral					
	Home/Bethesda-Chevy Chase, Inc., 7 Wisconsin Ave., Bethesda, MD 20814- 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,												7557 4=3501			
	23. PART I. Enter the di	seasea, or c	omplications the	ceused the	e death. Do	not ente	r the mo	de of dy	ing, auci	h as cerdie	c or reapir	atory ar	reat,	Approximate		
	shock, or heart fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Final												Interval Between Onset and Death			
	disease or condition resulting in death) Cardiopulmonary Arrest															
					NSEQUENCE C			-								
8	Sequentially list conditi	ona.	J		Lung		er									
CERTIFICATION	if any, leading to imme- cause. Enter UNDERLY!	diate	DUE TO	(OR AS A COI	NSEQUENCE C	IF):										
5	CAUSE (Disease or inju		DUE TO	OR AS A CO	NSEQUENCE C	E.										
Ē	resulting in death) LAS	т .												j		
8			1													
¥	PART II. Other significe	nt condition	s contributing to	death but n	ot resulting	in the u	nderlyin	g ceuse	given in	Part I. 2	La. WAS AN /		24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO		
MEDICAL										_ 1	YES 2			COMPLETION OF CAUSE DF DEATH?		
M										_				1 TES 2 NO		
ž.	DID TOBACCO U		RIBUTE TO CA					JUNC	ERTAIN	1 🗆						
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF OEA	OTHE	D.									
ΙΥS	1 YES 2 NO		1 Inputient 2			4 🗆 Nu	rsing Hon		sidenca	6 🗆 Other (S						
B	2 Accident	investigation	200 PLACE O	E IN ILIEN A	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IW			NO							
		Could not be determined	28a, PLACE Of building,	atc. (Specify)	it nome, term,	street, tec	tory, offic	:0		City or	ON (Street ar Town, State)	nd Numbe	r or Runal A	oute Number,		
<u>u</u>	29a. CERTIFIER															
MP	(Check only 1 X CEHT		CIAN: To the best of													
COMPLETED				amination and	I/or investigation	on, in my	opinion, c	leath occur	red at the	time, data an	d placa, and	29d. DATE SIGNEO (Month, Day, Year)				
H H	29b. SIGNATURE AND TITLE		Bis	M.	0				ENSE NUM							
2	20 NAME AND ADDRESS							D4	1373			>	May	11, 1995		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
	Said Baidas, M.D., 3800 Reservoir Road, N.W., Washington, DC 20007 31. DATE FILEO (Month, Day, Mar) MAY 12 1995 July Day Day, Said Baidas, M.D., 3800 Reservoir Road, N.W., Washington, DC 20007															
	31. DATE FILEO (Month, Day,	12 199	5 Julia	develor	Tardal	1										
			- 1/											- I		



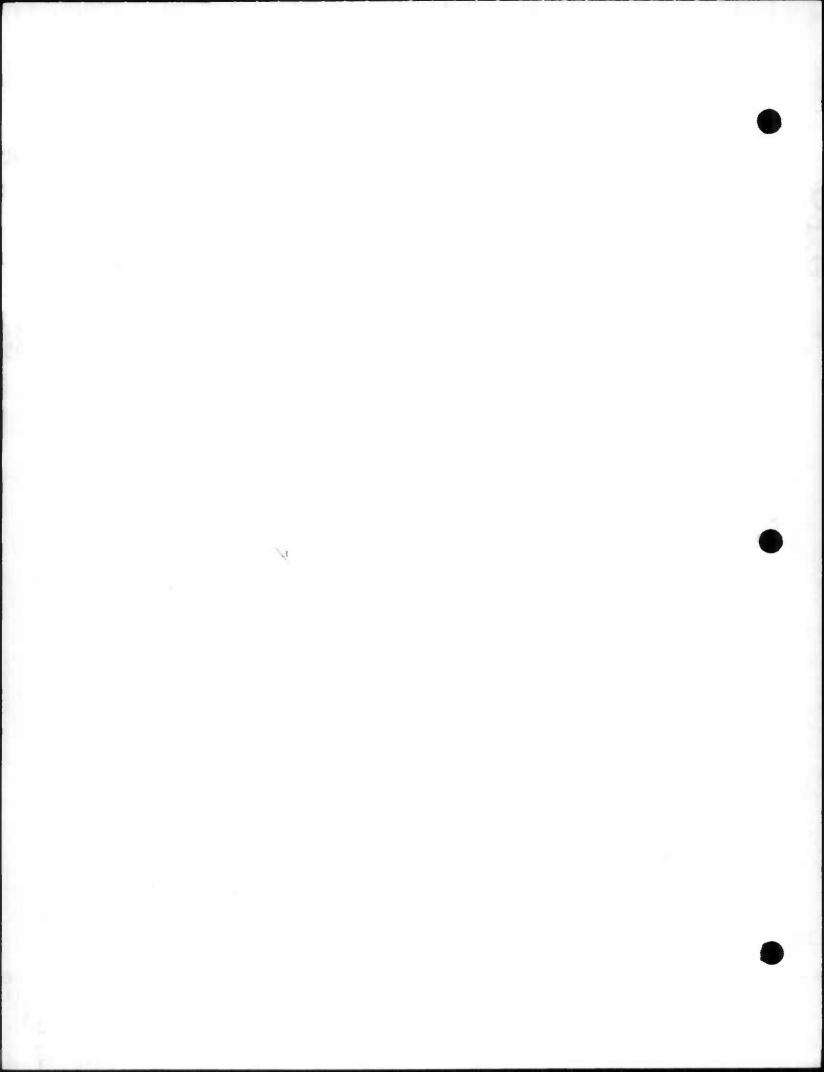
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. S BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

	HEGISTHAN				ENTIL	ICALE	E OF	DEA		F	REG. NO.				
	1. DECEDENT'S NAME (First, A			*						2. DATE OF	DEATH	ly .	VEAR		OF DEATH
	John	Newma	an	Libby						May	3 ⁿ	1	995		3:15 P _M
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. le	est birthday)	IF UNDER	-	IF UNDER		7. DATE OF (Month, D			6. BIRTH	PLACE (S	State or Foreign
	577-22-4879		1 🖾 M 2 🗌 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov.	12.	1922			nd
	9a. FACILITY NAME (If not insti	titution, give st	reet and number)			9b. CITY	, TOWN	R LOCATI	ON OF DE					-	
OR	Montgomery	Genera	al Hospit	:al		01	ney					Mo	In the cause (e) at the	mery	
5	RESIDENCE OF DECE	EDENT													
DIRECTOR		10b. COUNTY			1	Y, TOWN (TION						10d, INS	BIOE CITY
		Howar	ra		HI	ghla								1X YE	ES 2 NO
3A1	100. STREET AND NUMBER	1 -					101	ZIP CODE				10g. CIT			UNTRY?
FUNERAL	13160 Hollyl	och La					L_	207	//				USA		247
F	11. MARITAL STATUS 1 Never Married 2 🔀 M	farried	12. WAS OECEDEN FORCES? 1	T EVER IN U.S. A	RMED NO	13.	WAS DEC	ENDENT C	F HISPAN	NC ORIGIN? (S	pecify Yes	or No-	14. RACE Black	- Amer	ican Indian, atc.
BY	3 Widowed 4 Divorc		IF YES, GIVE W					2 📉 NO			,,		Speci		1
	15 DECEI	DENT'S EDUC	WW		ECEDENT'S	HELIAL OF	COLIBATIO							MII	ite
COMPLETED	(Specify only I	highest grade	completed)	(6	Give kind of a Do NOT us	work done	during mo	st of working	ng	166. KJ	ND OF BUS	SINESS/INI	DUSTRY		
2	Elementary/Secondary (0-1:	(2)	College (1-4 or 5 +	,	Aeros			inaa	٣		7.	ASA			
S	17. FATHER'S NAME (First, Mide	dle. Lest)	4		ICLUS	pace	Dile			ME (First, Midd				_	
	Mellen N. L	. ,						THE				,			
B	19a, INFORMANT'S NAME (Typ			10	DIS MAIL INC	ADDRESS	E /Stepal o			n Grace Smith Pural Route Number, City or Town, State, Zip Code)					
2	Susan Libby	,												1 2	0777
	20a. METHOD OF DISPOSITIO			20b. PLACE					,						
	1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 8 ☐ Other (S		ovel from State	cemetery, cr		ther place)		776 07							
	21. SIGNATURE OF FUNERAL		ENSEE	- CHILO	711 001			D ADDRES	SS OF FA						
	* Hanis	Tre	nt-H	olla	nd	1	1800	New	Ham	pshire	Ave	nue		incre	ar nome
	23. PART I. Enter the disc	Silver Spring, Maryland 20904 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between													
	immediate cause (Fine		List only one ceu	se on each lin	е.										terval Between
	disease or condition resulting in death)			/ ADM DA	Anu		Ans	-6	•	1715	EL X	6		1	
	readiting in death)		DUE TO	OR AS A CONSE	OUENCE O	F):	MIC	FR	y —	1/1/1	1751			1	(Es.
z	0		ı	OR ON OR AS A CONSE	TEL	N	15	KIT	25					1	(FAM.
CERTIFICATION	Sequentially list condition if any, leading to immedia	ate	DUE TO	OH AS A CONSE	CUENCE O	F):									- 1000
2	cause. Enter UNDERLYIN CAUSE (Disease or injury														
삠	that initiated events resulting in death) LAST		DUE TO	OR AS A CONSE	OUENCE O	F):									
斯			l												
ادّ	PART II. Other aignificent	condition	contributing to	deeth but not	reaulting	n the un	derlying	ceuse g	lven in	Part I. 24	. WAS AN	AUTOPSY	24b.	WERE AL	ITOPSY FINDINGS
EDICAL		12057	47/2 0	ANCER							PERFOR				LE PRIOR TO TION OF CAUSE
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						_ ''	YES 2	DANO		OF DEAT	
Σ.	DID TOBACCO US	E CONTR	BUTE TO CA	USE OF DEA	ATH YE	sПı	NO F	LINC	ERTAIN	V 158h				1 [] 16	S 2) NO
¥	25. WAS CASE REFERRED TO				CE OF DEAT	-		0.10	LICIANI	1/23/					
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER		a 5 □ Be	aldence	6 Other (Sc	nacify)				
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRI		JURY OC	CURED		
ВУ Р	1 Natural 5 Pe	ending vestigation	(Month, De	ly, rear)	(167)	URY M	1 🗌 1	RK7	NO						
	2 Sudalda	ould not be	28a. PLACE OF	FINJURY — At he	ome, ferm, i	Rreet, fect	ory, office	1		28f. LOCATIO	N (Street a	nd Number	or Rural R	loute Num	ber;
TED		termined	Danonig,	ates (opacity)						City or K	wn, State)				
2	29a. CERTIFIER (Check only	YING PHYSIC	CIAN: To the best of	my knowledge, d	eath occurr	ed at the ti	me, data	and place.	and due	In the causels) and man	nar en elei	ad		
COMPLET			3: On the basis of ax) end mer	nner as stated,
	296. SIGNATURE AND TITLE O		1						NSE NUN						
B	51	1	1-	m				17	2 4	247		APO. DAI	A.	moran, D	ney, rear)
유	36. NAME AND ADDRESS OF	ERSON WHO	COMPLETED CAUS		M 27) (Type	Print)			~)	ITI			77	2,1	445
						,									
	66	1			DIE	5/0	An.	0		au An	10 8 14		. det .		
	31. DATE FILED (Month, Day, Yes	TARRY	52. REGISTRAI	554		NO	4cs	Ra	2	CLAR	1454	NE	m	2	40 49



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YLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 20 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

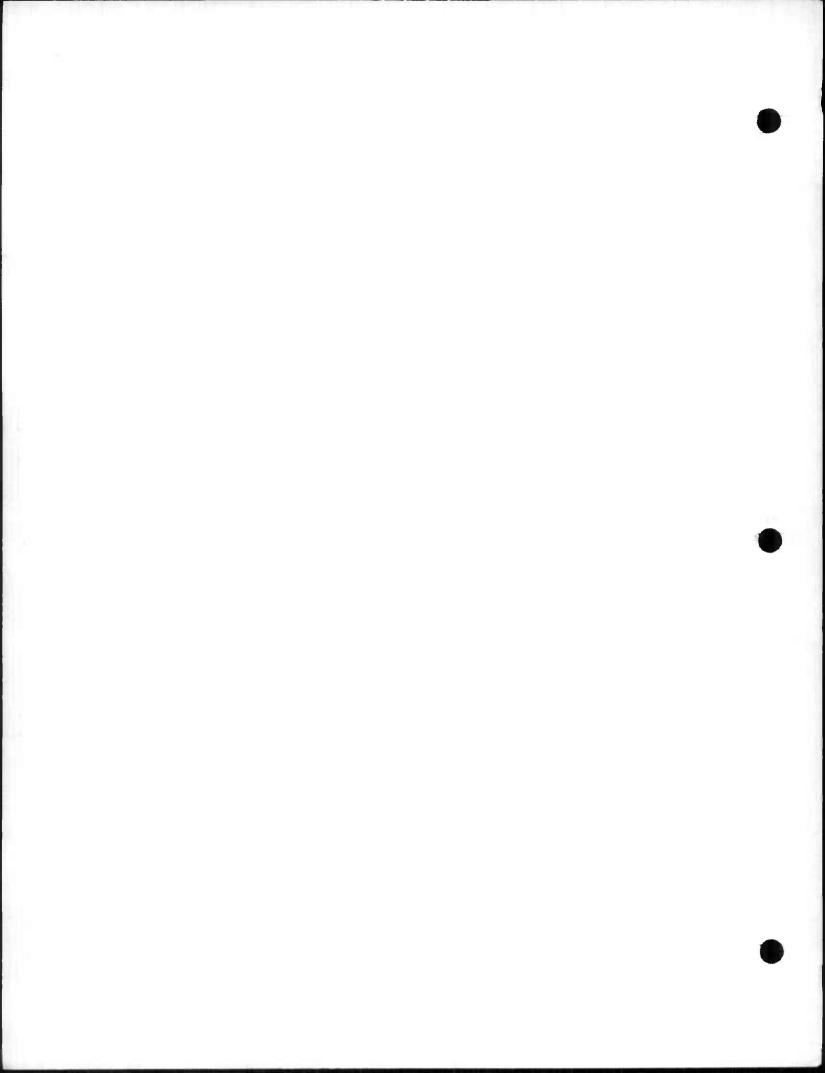
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9

												95		5979
	FOR 1 - STATE REGISTRAR	STATE OF !	MARYLAND /	DEPAR ERTIF					MEN		HYGIEN REG. NO	_		
3	1. DECEDENT'S NAME (First, Middle, Last)					DEA		2. D		DEATH			3. TIME OF DEATH
	Stephen	Sharp		Le	. (0	22/			MC	HTMC		AY	YEAR 95	430 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la:			R 1 YEAR	IF UNDE	R 24 HIRS.	7. D/		BIRTH		1 10	HPLACE (State or Foreign
	091-14-6629	1 M 2 - F	77	YRS.	MONTHS	DAYS	HOURS	MIN.			Ney, Year)	1917	Coun	try)
	9e. FACILITY NAME (If not institution, give	street and number)	. ,		9b. CIT	Y, TOWN (OR LOCATE	ON OF DE		ne	14,		INTY OF I	nnsylvania
DIRECTOR	Suburban Hospi	.tal			Ве	thes	da					Mon	tgom	ery
EC	10a. STATE 10b. COUN	тү		10c. CIT	Y, TOWN	OR LOCAT	TION							10d. INSIDE CITY
E	Maryland Mont	cqomery			Ro	ckvi	lle							LIMITS7
7	10e. STREET AND NUMBER					101	. ZIP COD	E				10a. C/1	IZEN OF	WHAT COUNTRY?
ER.	6012 Poindexte:	r Lane					20	852						States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF	RMED	13.	WAS DEC	ENDENT (NC OB	IGIN?	Specify Ve			
	1 Never Married 2 Married	FORCES? 1	MAD OD DATES			If yes, sp	ecity Cube	ın, Mexica	in, Pua	rto Ric	nn, etc.)			E — American Indian, ok, White, atc.
В	3 Wildowed 4 Divorced	1		WW II		1 123	2 23 110	Specify	у.				Spec	White
	15. DECEDENT'S ED (Specify only highest grad			ECEDENT'S					T	16b, K	ND OF BU	SINESS/IN	DUSTRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5	+) Iffe	. Do NOT us	se retired.)		IST OF WORK	ng						
MP		5+	Act	tor/M	usid	cian				E	nter	tainn	nent	
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)						18. MOT	HER'S NA	ME (Fir	st, Mid	de, Maiden	Surname)		7 7 1
BE		Otho Lewi									Shar			
2	19e. INFORMANT'S NAME (Type/Print)			b. MAILING										
	Mary L. Lewis	_		5012								e, Ma	ryla	and 20852
	20e. METHOD QE DISPOSITION 1	noval from State	20b.PLACE	and date of or of of of of of of of of of of of of of	of Dispos ther place Y	emat	me∘/Ma :oriu	y 9,	nc.	995		cation –		own, State Iaryland
	SIGNATURE OF FUNERAL SERVICE L	CENSEE ,	M	10084	6 R	hevy	Cha:	se,	SHY Inc	ey				/Bethesda- in Avenue
	23. PART V Enter the diseases, or	complications/thu	t caused the de	esth. Do r	not ante	r tha mo	de of dv	ing such	h se c	ardie	200	reton er	10T	Approximats
	SHOCK, OF HEST ISHUTE	List only one can	ise on each line	D.	00112-11					, , , , ,	or roup	ratory or	1001,	Intarvai Betwee
	IMMEDIATE CAUSE (Final disease or condition		f to				,*	/		0.0)			Onset and Deat
	resulting in death)	a. DUE TO	COR AS A CONSE	OHENCE OF	mc.	er	(1	net	ast	- CUC	uc)			~8400
-		ha	contacte (OR AS A CONSECULTIPE	20	1000			-0	0.40					
TIFICATION	Sequentially list conditions, if any, leading to immediate	b. OUE TO	(OR AS A CONSE	OUENCE OF	F):	V	ver			0				
IA	cause. Enter UNDERLYING													
Ĕ	CAUSE (Disesse or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	F):									
	resulting in death) LAST	d												
CEI	PART il. Other significant condition	ns contribution to	death but not a	novible a l	la sha au						Total I			
PHYSICIAN: MEDICAL	O as Constant Continue	contributing to	D 100 Day	enuiting i	in tha ui	nderlying	g cause g	given in	Part I	. 24	PERFOR		248	AWAILABLE PRIOR TO
ă	anemaco	milia	ruaco	pr	va	1000				1	YES 3	NO		OF DEATH?
Σ												,		1 TES 2 NO
N N	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN	<u> </u>					
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	OTHE									
YS	1 TYES 27 NO	17 Inputient 2		□ DOA			• 5 □ Re	sidenca	6 🗆 O	ther (S	pecify)			
표	27. MANNER OF DEATH 1 A Netural 5 Pending	28a. DATE OF (Month, D	INJURY ay, Year)	28b. TIM INJ	E OF URY	28c. INJI WO	URY AT RK?		28d. I	DESCR	BE HOW I	NJURY OC	CURED	
B	2 Accident Investigation				М		/ES 2 [NO						
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — A1 ho atc. (Specify)	me, farm, s	street, fac	tory, office			261. L	OCATION OF T	ON (Street a lown, State)	and Number	or Rural i	Route Number,
ZE I	29a. CERTIFIER 10 CERTIFYING PHYS	SICIAN: To the best of	my knowledge de	oth occur-	of at the f	lma dat	and eter:	and do	an ch		a) and			
M	(Crieck only													a) and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTURA		2		, my (,					- prave, en			10-10-20-20-20-20-20-20-20-20-20-20-20-20-20
H	THE OF CENTRAL		ms				29c. LICE	NSE NUM	ABER	2		29d. DAT		(Month, Day, Year)

28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide 29a. CERTIFIER 100 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examin on and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER D3956 5-8-95 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4743 20815 mp Chase

31. DATE FILEO (Month, Day, Year) MAY 11 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few and the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

					_			IOAI	<u> </u>	DEA			TEG. NO.			
		1. DECEDENT'S NAME (First)	iley	(no mide	lle.	name) Le	vis				2. DATE OF MONTH MAY	5, T	995	YEAR	3. TIME OF DEATH 5:21A
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	(In yrs. lasi	birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTH		A. BIRTI	IPLACE (State or Foreign
		230-30-8413		1 📉 M 2 🗆 F	68		YRS.	MONTHS	DAYS	HOURS	MIN.	March	ey. Year)	1927	Count	irginia
- 15	_	9a. FACILITY NAME (If not in		treet end number)				9b. CIT	Y, TOWN	OR LOCAT	ION OF DE	ATH		9c. COU	NTY OF D	DEATH
	DIRECTOR	Doctors Hos							Lanh	am				Pri	nce	George
		10e. STATE	10b. COUNTY	7			10c. CIT	Y. TOWN	OR LOCAT	TION						10d. INSIDE CITY
		Maryland		ce Georg	e			Laur	_							LIMITS?
	Z	10e. STREET AND NUMBER							1.7	ZIP COD				10g. CIT	IZEN OF V	WHAT COUNTRY?
	FUNER	8103 Pinehi	ll Str							2070	7				U.S.	Α.
	2	11. MARITAL STATUS 1 Never Married 2	945-14 A	12. WAS DECEDEN FORCES? 1	TEVER I	IN U.S. ARI		13.				IIC ORIGIN? (S n, Puerto Rica		or No-	14. RACI	E — American indien, k, White, etc.
- 1	BY	3 Widowed 4 Divo		FORCES? 1	AR OR D	ATES				24 NO					Spec	ttv:
				World W	Mar	2										white
			EDENT'S EDU			18e. DE6	CEDENT'S	USUAL C	during mo	ON asl of worki	ina	16b. Kil	ND OF BUS	INESS/INC	DUSTRY	
	4	Elementary/Secondary (0	3-12)	College (1-4 or 5	+)											
as !	COMPLET	Grade 8				Dr	ywal.	l In	stal	ler			Const	ruct.	ion	
90	ξ l	17. FATHER'S NAME (First, M	liddle, Last)							16. MOT	HER'S NA	ME (First, Midd	lle, Malden	Sumame)		
1 2	ш	unknown Let	wis							M	ary	Bennet	t			
	20	19a. INFORMANT'S NAME (7	Type/Print)			196	MAILING	ADDRES	S\$ (Street e	nd Numbe	r or Rural F	Poute Number,	City or Town	, State, Zic	Code)	
100	2	Mary Ann Ray	ynor						ourt			Laurel				20707
- E		20a. METHOD OF DISPOSITE	ION	ment from Ctot-		b. PLACE A				me of		DATE	20c. LO	CATION -	City or To	rwn, State
Ē		4 Donation 5 Other	(Specify)		Cen	Metr	o Cr	emat	ory			5/8	Cat	onsv	ille	, Maryland
in a		21. SIGNATURE OF FUNERA	r femmer no	ENSEE							SS OF FA					
the medical examiner must be notified at once.		Greye	/>	Kal		-		3	onal 313 T	dson albo	tt A	eral E venue	iome . Lau	rel,	Md.	20707
屋		23. PART i. Enter the di	seases, or c	omplications the	t cause	d the de	ath. Do r									Approximata
E		shock, or he IMMEDIATE CAUSE (Fin	eart failure.	List only one cau	isa on e	ech ilna.	1)	,							interval Between
흝	1	disease or condition	101	('M	0	The	4	An	15		^	1				Onset and Death
E E	H	resulting in death)		a. A / pde to	IORIAS I	A CONSEO	LIENCE OF	n .	~~	γ	Sind	1				Marcy
20 .	,			A41	cl	1		1	برت	De	. 6	Din es	-			1.00
other traumatic event,	HILLAHON	Sequentially list conditi		DUE TO	(OR AS	A CONSEO	UENCE OF	7:	-	30	10.0					7,00
E E	3	cause. Enter UNDERLY	ING													1
the	Ē	CAUSE (Disease or inju that initiated events		DUE TO	(OR AS	A CONSEO	UENCE OF	7:								
- I	Ē	resulting in death) LAS	Т .	d												
776	3	DART II Osh I III -														
any Injury.	EDICAL	PART II. Other aignifica	condition	s contributing to	death b	out not re	sulting I	n the u	ndariying	cause	given in	Part I. 24	PERFORE		24b.	. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
E 5	5 1	المحرر سابط	re de	efur U	Mo							1	YES 2	PONO		COMPLETION OF CAUSE OF DEATH?
51.5	¥												(1 TES 2 NO
23 sh	Y.	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE C	F DEAT	TH YE	s 🗆	NO [UNC	ERTAIN					
E 2	Š	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL			26. PLACI	E OF DEAT	H (Check	only one)							
r Item	<u></u>	1 YES 2 ONO		HOSPITAL:	ER/Outp	patient 3	□ DOA	OTHE		e 5 □ Re	esidence	8 Other (Sc	nec/fv)			
od, or		27. MANNER OF DEATH		28e. DATE OF	INJURY		28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRI		JURY OC	CURED	
			Pending Investigation	(Month, D	ey, 19 <i>er)</i>		INJ	URY M		RK? ES 2	NO					
5 C		3 Suitelde	Could not be	28e. PLACE O	F INJURY	— At hon	ne, farm, s	treet, fec	tory, office			28f. LOCATIO	N (Street as	nd Number	or Rural F	Poute Number,
2 1	U III		datermined	building,	arc. (Spec	сяу)					- 1	City or To	own, Stete)			
		29a. CERTIFIER TO CERT	IFYING PHYSIC	CIAN: To the best of	my know	riedge, des	th occum	d at the	time date	and place	and due	to the owners) and man			
ANT: If Item 2) end manner ee stated.
RTA			OF CENTIFIER					_			ENSE NUM					(Month, Day, Year)
हैं। ⋴	▫▮	·W	X	Mug		M	7			Di	>22	61		▶ S	-J	-5 T
≥ 5		30 NAME AND ADDRESS OF	PRASON WHO	COMPLETED CAUS	SE OF DE	ATH (ITEM	27) (7500	Print)	^						1	
		(weerand	U	teldin	- /	in	7.	100	BH	MAN	06 9	\sim	(AM	han	ans
		31. DATE FILED (Month, Day,		32. REGISTRA		-										
L		MAY 0	9 1995	Jalia di	إسعاره	x Ran	tall									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. In hours after death. Page 6 may be retained by the hospital or attending physician.

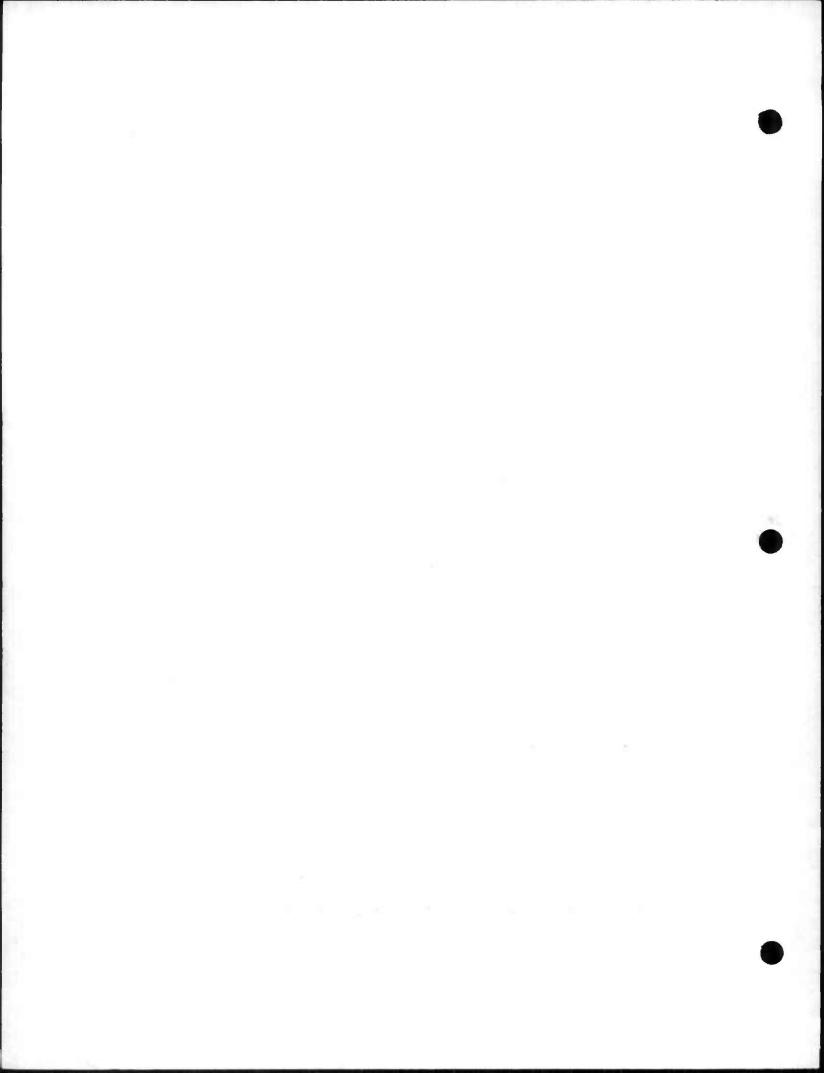
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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

1 - FOR STATE REGISTRAR

	REGISTRAR		CERTIFI	CATE OF	DEATH	R	EG. NO.		
į.	1. OECEDENT'S NAME (First, Middle, Last) MARIE HELE	N LIPS	COMB			2. DATE OF E	DAY	YEAR 995	3. TIME OF DEATH 7:50 P
25	4. SOCIAL SECURITY NUMBER 213-22-2971		E (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B		e pipri	HPLACE (Stote or Foreign
OR	9a. FACILITY NAME (If not institution, give sti SACRED HEART HOSP				DR LOCATION OF DEA	ATH	1	ALLE	DEATH
DIRECTOR	PENNA BED	FORD		TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS? V
RAL	10e. STREET AND NUMBER RFD#3 BOX# 235	2010		10	f. ZIP CODE				1 TYES 2 THE NO
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Werried	12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DE	15522 CENDENT OF HISPANI	C ORIGIN? (Sp	ecify Yes or No-	U.S.A	E — American Indian,
BY	3 Widowed 4 Divorced	IF YES, OIVE WAR OR	DATES	1 🗆 YE	2 NO Specify:			Spec	WHITE
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	16a. DECEDENT'S U (Give kind of we life. Do NOT use HOUSE K	ork done during m retired.)	DN ost of working		OF BUSINESS/II	0.000	
8	17. FATHER'S NAME (First, Middle, Last)		I HOUSE K	DLI DK	18. MOTHER'S NAM				
BE C	JOHN BARCLAY				ANNA S	PIKER			
2	MELVIN LIPSCOMB		RFD#3	BOX#235	BEDFORD			lip Code)	
	20. METHOD OF DISPOSITION 1 Mauriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)		SUNSET CEM	ETERY	MAY 17 1	995	CUMBERL		MARY LAND
	21. SIGNATURE OF FUNERAL SERVICE LO	own the		MERRÍ 404 D	TT-ADAMS ECATUR ST	FUNERA	L HOME	ND MA	ARYI.AND
	23. PART I. Enter the diseases, or co shock, or heart fellure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Bowe	l Phstu	ection					Approximats Interval Batween Onset and Dasth 2 DAYS
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	doma					3 YEARS
	PART II. Other significant conditions	contributing to death	but not resulting in	the underlyin	g ceuee given in P	art I. 24s.	WAS AN AUTOPSY	/ 24b	. WERE AUTOPSY FINDINGS
EDICAL	Chronic Obstac	ore	مرير طينية	sc.		_ 1 -	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
AN: M	DID TOBACCO USE CONTR		OF DEATH YES	□ NO 1	UNCERTAIN				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO	HOSPITAL:		OTHER:	e 5 Rasidence 6	☐ Other (Spe	cffy)		
ВУ РН	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	INJU	M 1 🗆	PRK? YES 2 NO	28d. DESCRIB	E HOW INJURY OF	CURED	
	3 Suicide B Could not be determined	28e. PLACE OF INJUI building, etc. (Sc	RY — At home, farm, streedly)	eet, tectory, offic		28t. LOCATION City or Tow	(Street and Numbern, State)	or Rural F	loute Number,
COMPLETED	29e. CERTIFIER (Check only one) HEDITAL EXAMINER	AN: To the best of my kno	wiedge, death occurred ion end/or investigation,	at the time, date	end place, end due to	o the cause(s) me, date end p	end manner as st	itled. The couse(a	i) end manner es stated.
TO BE	29b. SIGNATURE AND THE BY CENTIFIER	MO			D23167	ER			(Month, Day, Year) 15, 1995
-	DR. JUAN ARRISUEN				UMBERLANI), MD 2	21502		
	31. DATE FILED (Month, Day, Year) MAY 1 6 199	A2. MIGHSTRAR'S SIC		-					



* BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an interpretal. Page 6 may be retained by the hospital or attending physician.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		UE	EKIIF	ICALE	OF	DEATH	R	IEG. NO.			
100	1. DECEDENT'S NAME (First, Middle, Last) INEZ	IMI			LEWIS			2. DATE OF MONTH MAY	DAY	, 19	995	3. TIME OF DEATH 1325 P M
	4. SOCIAL SECURITY NUMBER 217–66–7653	5. SEX 6	R. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I	HOTH		8. BIRTH Count	IPLACE (State or Foreign
ij	9a. FACILITY NAME (If not institution, give str	0.44	04		DL OUTY T		R LOCATION OF DI		2,17			ryland
œ	Sacred Heart He						rland	EATH		1	UNTY OF D	
DIRECTOR	RESIDENCE OF DECEDENT	Sprear			ou	me	riand	_		E	lleg	any
Ä	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCAT	ION					10d. INSIDE CITY
5	Maryland Alle	gany		F	rostb	urg						1 VES 2 NO
FUNERAL	10a. STREET AND NUMBER	-				101	ZIP CODE			10g. CI	TIZEN OF Y	WHAT COUNTRY?
E	185 S. Water	st.				1	21532			T	S.A	
3	11. MARITAL STATUS	12. WAS DECEDENT			13, WA	S DEC	ENDENT OF HISPAN	VIC ORIGIN? (S	pecify Yes			E American Indian, k, White, atc.
E E	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1		10			2 NO Specifi		n, atc.)		Spec	white White
	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed	16a. DE(CEDENT'S	USUAL OCC	UPATIC	N of weekler	16b. KIN	D OF BUS	INESS/IN		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT us	vork done dur se retired.) aker	ing mo	st of working		Own	n Ho	me	
\$	17. FATHER'S NAME (First, Middle, Last)			_			40 4407					
	James D. Richa	rds					16. MOTHER'S NA	me (First, Middl ret We				
B	19a. INFORMANT'S NAME (Type/Print)	11 (15)	1 405		4000000		9	_		2		
임	Doris Myers		190				, Frostb					
	20a. METHOD OF DISPOSITION		20b. PLACE A						_		- City or To	own. State
	# Burlel 2	val from State	Frost	patory or of	Memor	ria	l Park					Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			-	_	O ADDRESS OF FA				Ave	
	Arken for	Horn			Dun	rst	Funeral					Md. 21532
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	A 5UE TO (0	R AS A CONSEQ HAS A CONSEQ	THE DENCE OF	ena	ln.	Maria	m	/ U//.		-	4 gen
- 11	PART II. Other significant conditions	contribution by	eath but not e	anultina i	toa	all of the late	anne atre te	nor Lo	WAS AN A			
I: MEDICAL	DID TOBACCO USE CONTR	e of	rter	1/2	er ya Disi	ue	UNCERTAIN	_ 10	PERFORM		240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
Z	25. WAS CASE REFERRED TO MEDICAL				H (Check only		ONCERIAN					
25		HOSPITAL:			OTHER:		6 Bestdoor	e 🗆 000		-		
Y PHYSICIAN: M	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF IN (Month, Day,	JURY	28b. TIMI	E OF 28 URY	Bc. INJI	JRY AT RK?	6 ☐ Other (Sp 28d. OEŞCRIE		JURY OC	CURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be defarmined	28a. PLACE OF I	NJURY — At hor :. (Specify)	ne, ferm, s	treet, fectory	, office		281. LOCATIO City or To	N (Street an wn, Stete)	nd Numbe	or or Rural F	Route Number,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINER	IAN: To the best of m) and manner ea stated.
IO BE	296. SIGNATURE AND TITLE OF CENTIFIER	1 lm	Th.	/	70		294- UCENSE NUN	195				(Month, Day, Year) 1, 1995
		D., 48 T.	ARN TER	RACE	, FRO	STB	URG, MD	21532				
	31. DATE FILED (Month, Day, Year) MAY 1 5	1995	SIGNATURE	Rord	all							

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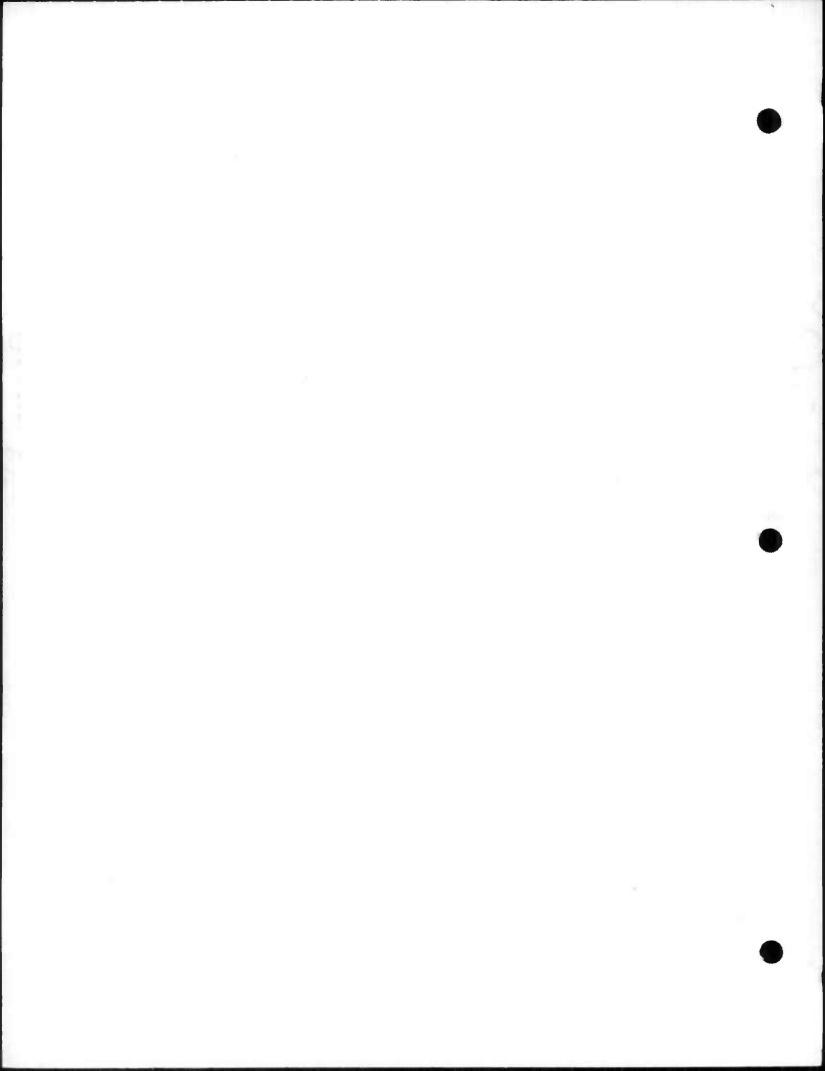
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely that in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hydrone price to be the transmitted of the permitted of the properties of the properties of the properties of the properties of the permitted of the properties of the permitted of the permit BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

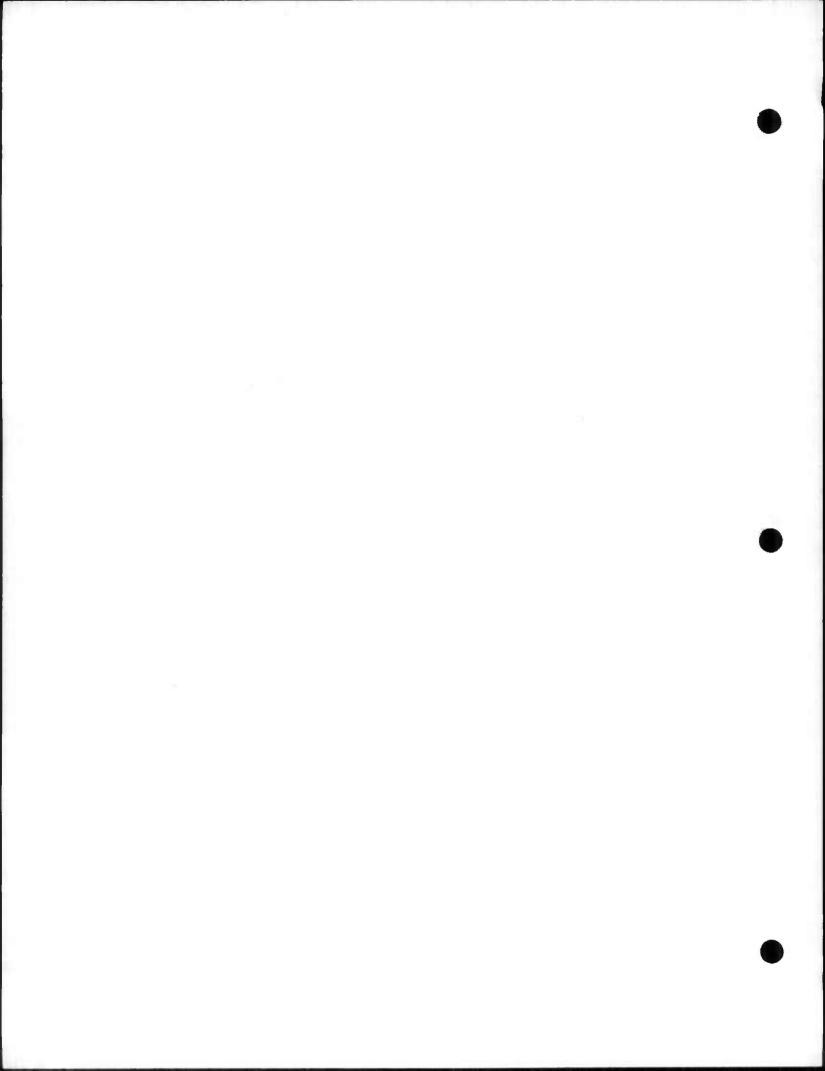
						IOAII	- 01	DEA			HEG. NO.			
	1. DECEDENT'S NAME (First, A	fiddle, Last)									TE OF DEATH			3. TIME OF DEATH
1	WILSO	N		T.AR	GENT						RIL 2		995	10./1 DW
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. I		IF UNDE	A MEAN	T		-		9 1	///	18:41 P M
			11,57			MONTHS	DAYS	HOURS	PI 24 HRS.	7. DA	TE OF BIRTH		8. BIRTHP	PLACE (State or Foreign
	217-10-0458		1 🔀 M 2 🗆 F	80	YRS.			I HOUNG		μun	e 4,191	4	West	Virginia
	9e. FACILITY NAME (If not insti	tution, give s	treet end number)			9b. CIT	, TOWN	OR LOCAT	ION OF D	EATH		Bc. COL	INTY OF DE	ATH
OC.	Memoria	al Ho	spital			C	ımbe	er1an	d				legan	
12	RESIDENCE OF DECE						umbe	EL Tail	ICI			AL	Tegan	Ly
DIRECTOR		OB. COUNTY	,		T 40 - 00	Y, TOWN			_					
2	WV		Mineral			,								10d. INSIDE CITY LIMITS?
	- "V		unierar		Wi	1ey	roro	1						1 TES 2 NO
1 2	10e. STREET AND NUMBER						10	H. ZIP COD	E			10a, CI1	IZEN OF WI	HAT COUNTRY?
FUNERAL	Clearvie	ew Ave	enue					267	67				S.A.	
2													Б.Д.	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A		13.	WAS DE	CENDENT	OF HISPAI	VIC ORI	GIN? (Specify Yes to Rican, etc.)	or No-	14. RACE	- American Indian, White, etc.
BY	1 Never Married 2 X M		IF YES, GIVE W]110			2 X NO			o rican, etc.)		Specify	
	3 Widowed 4 Divorce	ed						2-12	,,,,,,,,				4,000.7	White
COMPLETED	15. DECED	ENT'S EDU	CATION	16a. C	ECEDENT'S	USUAL O	CCUPATI	ON			6b. KIND OF BUS	INESS/IN	DUSTRY	
16	(Specify only h			- A	Give kind of fe. Do NOT u	work done se retired.)	during m	ost of world	ing					
1 7	N/A	4)	College (1-4 or 5 d		Carme						Rail	Road		
. ₹								,						
8	17. FATHER'S NAME (First, Midd Hetzel Ta		Loncont					18. MOT	HER'S NA	ME (Fin	t, Middle, Malden	Sumame)	211	
BE	netzer 18	aylor	Largent	_				l ve	rna	LS	tella	Cowg	111	
	19a. INFORMANT'S NAME (Type	a/Printy		1	96. MAILING	ADDRES	S (Street	and Numbe	r or Rural i	Route N	imber, City or Town	2. State. Zi	n Codel	
2	Minnie M. 1	Large	nt		P. 0	. Bo	x 36	50.	Wile	v F	ord, WV	2.6	767	
				_						_				
	20a METHOD OF DISPOSITION 1 № Burtal 2 □ Cremation	3 🗆 Repu	oval from State	20b. PLACI	EAND DATE	OF DISPOS	SITION (M	ame o/	M	0	TE 20c. LO	CATION -	City or Tow	n, State
	4 Donation 5 D Other (S)	peolyl //	/d A	Fores	ST '' 'G1	enroe	met	ery i	may .	. ۋىك	1995 G	reen	sprin	g, WV
	21. SIGNATURE OF FUNERAL S	semilian Lic	meter //	,		22.	NAME A	NO ADDRE	SS OF FA	CILITY	l Home,	-		
1 1	/VI	VI	V12. V/1											
	1 Hen	IK.	1 VWV 1	1							St., Ron			26757
	23. PART I. Enter the disc	eses, or c	omplicationa the	t caused the d	leath. Do	not antar	the mo	ode of dy	Ing, auc	h as c	rdiac or respi	ratory ar	rest,	Approximate
			List only one chu	se on each iin	Mi.									Interval Between
	IMMEDIATE CAUSE (Final disease or condition		V	_										Onset and Death
	resulting in death)	> ,		Inferi			lyoc	ardi.	al I:	nfa	rction			3 Days
	ACCOMPANIES ACCOMPANIES		DUE TO	(OR AS A CONSI	EQUENCE O	F):								
2			h.											
12	Sequentially list condition if any, leading to immedia		DUE TO	(OR AS A CONSI	EQUENCE O	F):								
18	cause. Enter UNDERLYING	G												
	CAUSE (Disease or injury that initiated events	1	DUE TO	(OR AS A CONSI	FOLIENCE O	E)·								+
ΙĒΙ	resulting in death) LAST				- 11	,,								i .
CERTIFICATION			1											
	PART II. Other eignificant	condition	a contributing to	deeth but not	regulting	In the ur	dedula		aluna la	Don't I	24a, WAS AN			
EDICAL				acom but not	resulting	iii tire ui	idellyili	g ceuse :	Aiseil III	Part I.	PERFOR			WERE AUTOPSY FINDINGS
18											1 TYES 2	X NO		COMPLETION OF CAUSE OF DEATH?
	,													YES 2 NO
2	DID TOBACCO USI	CONTE	RIBLITE TO CA	LISE OF DE	ATH V	S D I	NO F	1 LINIC	EDTAIN					
X	25. WAS CASE REFERRED TO A		CIDOTE TO CA		CE OF DEA				CKIAH	1 67				
0	EXAMINER?	- LONG	HOSPITAL:			OTHE								
PHYSICIAN:	1 TES 2 X NO		1 Inpatient 2	ER/Outpatient	3 🗆 DOA			10 5 🗆 Re	esidence	6 🗆 OI	her (Specify)			
포	27. MANNER OF DEATH		28s. DATE OF (Month, De	INJURY	28b. TIM	E OF	20c. IN.	URY AT		28d. E	ESCRIBE HOW IN	JURY OC	CURED	
	1 X Natural 5 Pe	nding estigation	į inomi, o	-y, 100//	1	M		YES 2	□ NO					
BY	3 Sulaido		26e, PLACE O	F INJURY — At h	ome, farm.	street fact	nry offic			204 17	CATION (Street e	ad Alumba	a a Cumi Da	do Musebas
	_ 0 0	uld not be ermined	building,	atc. (Specify)			o. y, o		l	C	ty or Town, State)	na numoe	or nural not	ute Number,
COMPLETED	V													
14	29e. CERTIFIER (Check only	YING PHYSIC	CIAN: To the best of	my knowledge, d	leath occurs	ed at the t	lme, date	end place	, end due	to the	ause(e) end man	ner as sta	ted.	
\ <u>₹</u>														and manner as stated.
8		u		7				_			press also		· · · · · · · · · · · · · · · · · · ·	manufi de states.
B	296. SIGHATUHE AND TITLE OF	CENTIFIER		/)				29c. LICI	ENSE NUN	IBER		29d. DAT	E SIGNED (A	Wonth, Day, Year)
	/ X / / E	an	un.	16				D:	28910	0	- 1	DA.	11/3	10 1995
유	38. MAME AND ADDRESS OF P			OF DEATH (ITI	EM 27) (Type	Print)				-		DY	- 7/	, (113
	DR. C.H. MER						TAT	RIDC	CID	MREI	A CINA IS	/D		
] 1						TUD I	'EZT'	טעיים	, 001	נמטו	THAME, I	ш		
	31. DATE FILED MANY DEL YE	1995	SE. WELDIS INCA	R'S SIGNATURE	dall									
1 38	4111111 0 0	1000												



DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND 21215-0020

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE
REGISTRAR	CERTIFICATE OF DEATH REG. NO.

_		STATE REGISTRAR		STATE OF N		/ DEPAI CERTIF					ENTAL HYGIEN REG. NO			
	i	1. DECEDENT'S NAME (First, Steven Le	ewis								2. DATE OF DEATH MONTH D		YEAR 8	TIME OF DEATH 15PM M
		4. SOCIAL SECURITY NUMB 233-33-078		5. SEX	8. AGE (In yrs. 13	lest birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER :	MIN.	7. DATE OF BIRTH (Month, Day, Year) May 18 19	981	a. BIRTHPL Country) West	ACE (State or Foreign Virginia
8		Memorial 1						TOWN O	and	N OF DEA	тн	9c. COUN	egany	
DIRECTO		RESIDENCE OF DEC	10b. COUNTY			10c. CIT	Y, TOWN O							d. INSIDE CITY
	- 86	WV 10e. STREET AND NUMBER	Mir	neral		F	leyse							LIMITS? X
FUNERAL		Rt. 5,	Box 30)9				2	21P CODE 26726			U.	S.A.	AT COUNTRY?
D BY FUI		11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo	Married	12. WAS DECEOENT FORCES? 1 IF YES, GIVE W	YES 2	ARMED XNO	1	yes, spe		, Mexican,	ORIGIN? (Specify Yer Puerto Rican, etc.)	or No—	14. RACE — Black, W Specify: Whit	American Indian, White, etc.
			EDENT'S EDUCA highest grade co		_	Give kind of life. Do NOT u	work done d			,	Keyser			1001
BE COMPL		17. FATHER'S NAME (First, MI John	. ,	Lewis					18. МОТН	reci	E (First, Middle, Maiden			
2		Johnny I		is		Rt.	ADDRESS 5, Bo	(Street en	09,	Keys	er, WV	n, State, Zip 2672	Code) 26	
must be		28e: METHOD OF DISPOSITI 1 Denation 5 Other	n 3 🗆 Remov (Specify)	00 11		e AND DATE				May	5,1995	Poin		State WV
CASHIIII		21. SIGNATURE OF FUNERAL	SERVICE LICE				S 22.1	hafi 30 E	er F East	of FACI uner Main	al Home, St., Rom	Inc.	WV 26	757
Injury, or other traumatic event, the medical		23. PART I. Enter tha di shock, or he inches or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition and list any, leading to immedicause. Enter UNDERLYII CAUSE (Disease or injurthat initiated events resulting in death) LAST	ai a. ons, flate NG ry	Multipl DUE TO (e ches	na. St tra SEQUENCE O	uma Fi:							Approximate Interval Between Onset and Deeth 2 hours 2 hours
CAL		PART II. Other algnificat	nt conditions	contributing to (death but no	t resulting	in the une	derlying	cause gi	ven in P	24a. WAS AN PERFOR	MED?	AM CO OF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
YSICIAN: MED	- H	DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	BUTE TO CAL		ATH YE	TH (Check a	nly one)	UNCE	RTAIN			1	YES 2 NO
		1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 F Accident 3 Suicide 8 C	Pending nvestigation Could not be letermined	28e. DATE OF I (Month, De May 2 1 28e. PLACE OF building, e	NJURY y, Year) 995 INJURY — At	6:45	E OF URY PMM	28c. INJU WOR 1 YE	RY AT	NO I	other (Specify) Open Describe How is assanger that hit 1 st. LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (Street LOCATION (STREET LOCATION (STR	ixed	vn fro	om truck
BE COMPLET		29e. CERTIFIER (Check only	FYING PHYSICIA	Highwa N: To the best of r On the basic of axi	ny knowledge, amination end/c	death occurre	n, In my op	inlon, de	sth occured	d at the Hr	the cause(e) end mer ne, data and pieca, an ER	ther se state d due to the 29d. DATE	d. ceuse(e) en	onth, Day, Year)
\$ 2		Paul Snow,	M.D.	124 w 3	E OF DEATH (IT	EM 27) (Type,	Print)					1		
		MAY 08	995	32. REGISTRAR	S SIGNATURE	4								



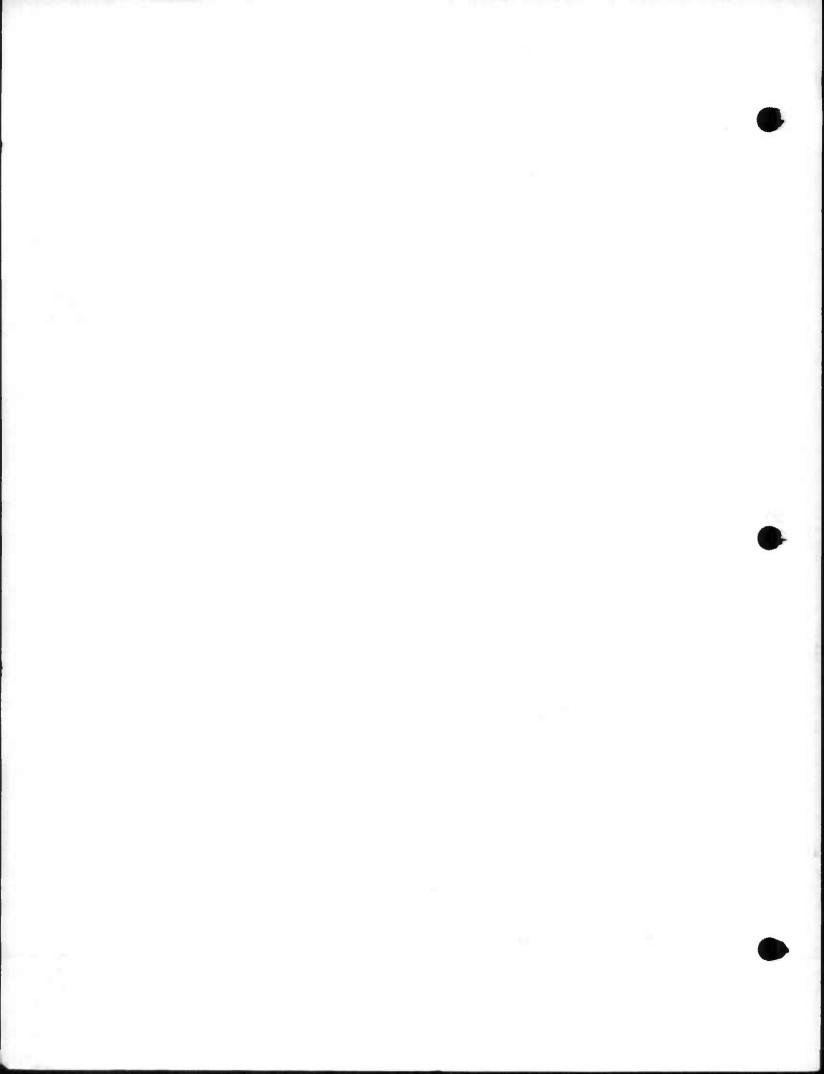
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		ÇE	RTIFIC	ATE OF	DEATH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) ALVA C. LEWIS						2. DATE OF DEATH	1 995	YEAR	3. ZIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 236-20-9929	5. SEX 6. /	AGE (In yrs. lasi 71		UNDER I YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH DEC 4, 19	23	8. BIRTHI Country	PLACE (State or Foreign
OB	90. FACILITY NAME (If not institution, give s CUPPETT WEEKS NU			- 1	CITY, TOWN	OR LOCATION OF DE	EATH		RETT	
티	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ν		10c CITY T	OWN OR LOCA	TION				44.4 110000 0171
- DIRECTOR	MD Carr				sburg					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3000 Gamber Road	i				21048		USZ		HAT COUNTRY?
ΒY	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1 X IF YES, GIVE WAR ON THE TOTAL TO	ER IN U.S. ARM YES 2 NO DR DATES	IED D	Il yes, sp		NIC ORIGIN? (Specify Youn, Puerto Rican, etc.) y:	s or No—	Black,	- American Indian, White, atc. White
윤	15. DECEDENT'S EDU (Specify only highest grade				JAL OCCUPATE done during m		16b. KIND OF BU	ISINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. I	Do NOT use re	Presi		Rubbe	er Wor	kers	Local
	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maide (Bramble)	Surname)		
BE	William Lewis 19a, INFORMANT'S NAME (Type/Pript)		190.	MAILING AD	ORESS (Street		Route Number, City or To	en State 7in	Code	
임	Mary Sue Lewis Mary Jo Harry						andallstow			133
	20e. METHOD OF DISPOSITION 1 Mariel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from Stata	20b. PLACE AI cemetery, crem Mary I	nd date of d natory or other and V	eteran	_{eme of} s Cemete:	05/06 F.	CATION — C Lintst	one,	m, Stata MD
	21. SIGNATURE OF FUNERAL SERVICE LI	7 VCan	so li	/_	Scar	pelli Fu erland, I	neral Home	!		
	23. PART I. Enter the diseases, or shock, or heart fellure.	complications that ca	sed the dee	th. Do not				piratory arr	est,	Approximata
	IMMEDIATE CAUSE (Final	List only one cause o	on eech line.							Onset and Death
ļ	disease or condition resulting in deeth)	. liver fai	lure							2 weeks
,	_	obstructi								2 weeks
힏	Sequentially list conditiona, if any, leading to immediate		AS A CONSECU							
<u>১</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury	<u> metastati</u>								l year
CERTIFICATION	that initiated eventa resulting in death) LAST	adenocarc	AS A CONSECU		0010					2 ****
Ü										3 years
PHYSICIAN: MEDICAL	PART II. Other algnificent condition	ns contributing to dea	th but not re	aulting in t	he underlyin	g ceuse given in	PERFO	RMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
밀							1X YES	2 NO		OF DEATH? 1 TYES 2 TY NO
ž	DID TOBACCO USE	CONTRIBUTE 1	O CAUS	E OF I	DEATH	YES NO	D IZ			A rec o M
CH	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				LACE OF DEATH (Ch	eck only one)			
KS	1 YES 2 X NO 27. MANNER OF DEATH	1 Inpatient 2 ER		DOA 42			8 Other (Specify)			
ВУ РН	1 X Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJU (Month, Day, Y		28b. TIME O	r W	JURY AT ORK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCC	URED	
- 11	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF IN- building, etc.	JURY — Al hom (Specify)	ne, larm, stree	el, factory, offic		281. LOCATION (Street City or Town, State	and Number	or Rural Ro	oute Number,
COMPLETED		ICIAN: To the best of my								and manner as stated,
띪	196 SIGNATURE AND TITLE OF CERTIFIE	R	M			29c. LICENSE NUI D 25759		29d. DATE	SIONED	(Month, Day, Year) 1995
임	30. NAME AND ADDRESS OF PERSON WE Walter K. Nauman					etery Ros	ad. Accide	nt MD	2153	20
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S		.,, 1	J JEIII	TOLY NO	,		217	
	MAY 0 5 1995	Me Midon								

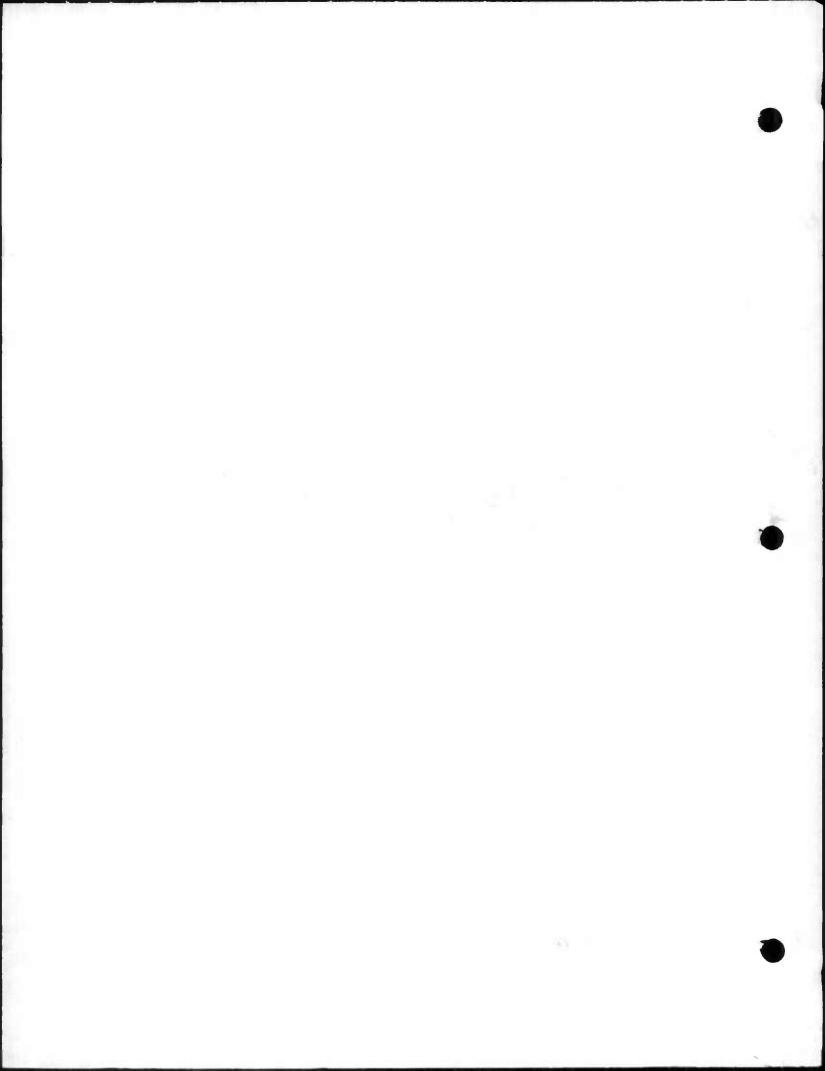
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

SBALTIMORE, MARYLAND 21215-0020



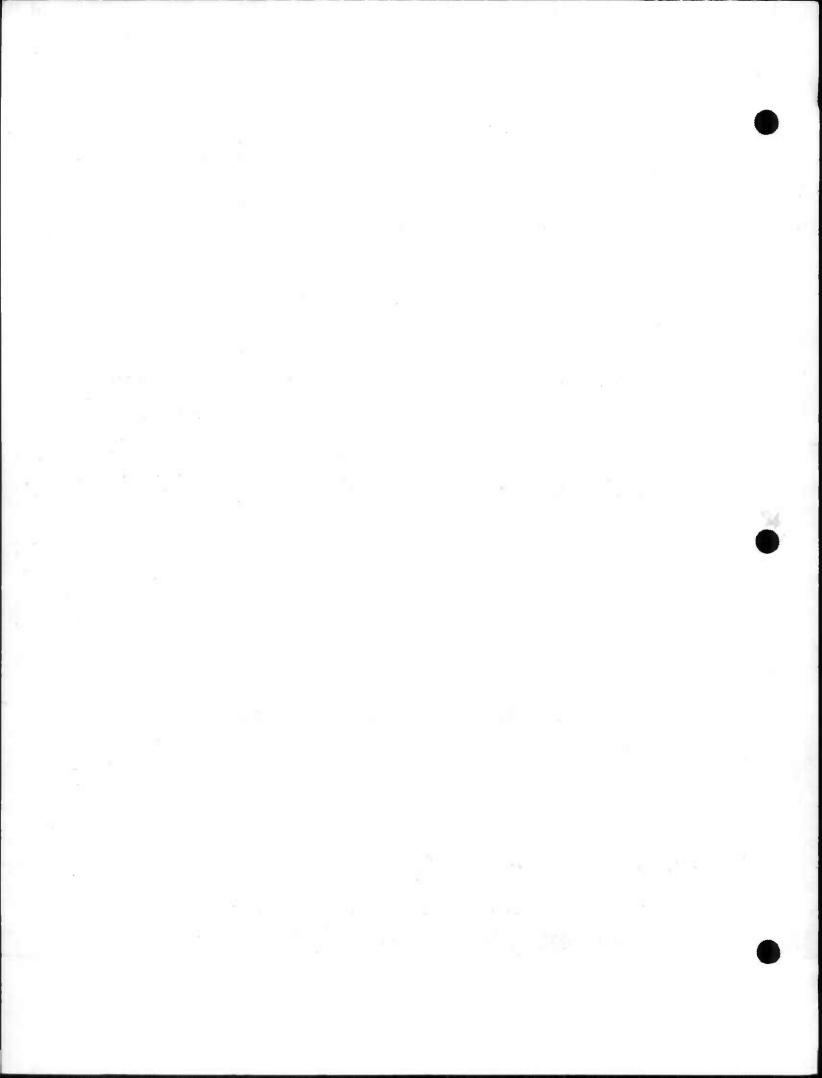
1 - STATE REGISTRAR

		1. DECEDENT'S NAME (First		,							2. DATE OF D	DAY		YEAR 3.	. TIME OF DEATN
		Hazel E1		110	Afee				_		May		L995		12:50 P w
		217-09-0925	SER	5. SEX	6. AGE (In yrs. Is	st birthday) YRS.	IF UNDER	DAYS	HOURS	R 24 HRS. MIN.	7. DATE OF B (Month, Day	(Year)	- 1	Country)	ACE (State or Foreign
pinous		9a. FACILITY NAME (If not in	astitution give s	21	92	THO.	as CIT	7 700001	001001	ION OF DE	Apr. 2				
ന	œ.	Frederick			± o 1				rick	ION OF DE	ATH		9c. COUNT		
1, 2,	15	RESIDENCE OF DEC	EDENT		Lai		11	edel	LICK				Fre	deri	CK
Sages	DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					10	0d. INSIDE CITY LIMITS?
permit. Pages		Maryland 100. STREET AND NUMBER	Fred	erick		Th	urmo							1)	YES 2 NO
	RAL	424 N. Chu	wah C+					10	H. ZIP COD			3	10g. CITIZE		AT COUNTRY?
020 physician. burial-transit	FUNER	11. MARITAL STATUS	ICH SE	12. WAS DECEDEN	IT EVER IN ITS. A	MED	1 42	WAS DE	2178		IC ORIGIN? (Sp			USA	
5-0020 nding physic is the burial		1 Never Married 2		FORCES? 1	YES 2 X	NO	- 1	II yes, sp	pecify Cubi	en, Mexican	i, Puerto Rican,	, atc.)	r No 1	Black, V	- American Indian, White, etc.
215-0020 attending physician. se as the burial-tran	B √	3 X Widowed 4 Divo	reed					1	2 170 140	эрвону.				Specify:	White
r atte	COMPLETED		EDENT'S EDUC highest grade		(0	ECEDENT'S	work done	CCUPATI during me	ON ost of world	ing	16b. KIND	OF BUSIN	ESS/INDUS	STRY	
AND 21 the hospital or detached for u	빌	Elementary/Secondary (0	⊢12 }	College (1-4 or 5	+)	. Do NOT u	,								
AND he hospit detached	OMI	17. FATNER'S NAME (First, M	iddle Last)			Seam	stre	SS	T 40 4407	THE BIG MAA	ME (First, Middle		g Fa	ctory	<u> </u>
2 8 8	E G	Elmer Wolf	,								ane St				
MAR retained to 5 should	8 0	19a. INFORMANT'S NAME (7	i/pe/Print)		19	b. MAILING	ADDRESS	S (Street I			oute Number, Ci			orde)	
(I) ma		Clayton Nor	nan Mc	Afee (So							urmont				
ORE, le may be ctor, page	90	20s METHOD OF DISPOSITI	ON 3 I Barry	ound from State	20b. PLACE	ANDDATE	OF DISPOS	HTON /N	irme s/				TION - OR		State
mm 0 m		4 🗆 Donation 5 🗆 Other	(Specify)		Blue	Rid	ge C	emet	ery		5/15	Thur	mont	, Mar	ryland
ALTIMORE, death. Page 6 may be have director, page	examinor	21. SIGNATURE OF FOREBA	A SERVICE UC	C) La	1		22. R	OBER	ND ADDRE	DATI	LEY &	SON F	TIMER	AT HC	OMES, P.A.
		Soker	66	Larle	47		6	15 E	AST	MAIN	STREET	THU	RMON	r Mr	21788
1 2 2 2	0000	23. PART I. Enter the di shock, or he	seases, or c	omplications the	t saused the de	sath. Do r	ot enter	the mo	ode of dy	ing, such	as cardiac o	or respirat	lory arres	t,	Approximate
for the second		IMMEDIATE CAUSE (Fin		0	L L	1.		1	1 months of the		1	2			Onset and Death
6 6 2		disease or condition resulting in death)	→ ,	1/10	and	1u	ft	de	ino	-	Col	12			4 400
				DUE TO	(OR AS A CONSE	QUENCE O	P)				- 8				
X 68	CERTIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	OR AS A CONSE	DUENCE O	P):							-	
	8	cause. Enter UNDERLYI CAUSE (Disease or Inju	NG .												
O H BH	E	that initiated events resulting in death) LAS		DUE TO	OR AS A CONSE	DUENCE O	Pi .							1	
U 6 8 1	5 5	resoning in dentity ERS		ı											
DS the		PART ii. Other significa	nt condition	contributing to	death but not	reauiting	in the un	deriyin	g cause	given in F	Part i. 24a.	WAS AN AU		24b. WE	ERE AUTOPSY FINDINGS
ECORDS quires that the d signed by the Health and Me				5001	m						- 1	PERFORME YES 2		00	MILABLE PRIOR TO OMPLETION OF CAUSE
RECO requires the												,	,	1	F DEATH?
S 20 41 "	ä	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲 I	NO [JUNC	ERTAIN					
VITAL IAN: The law tificate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLA	E OF DEAT	OTHER								
F VIT.	IS	1 TYES 2 THE		1 Impatient 2			4 🗆 Nun	ing Nom	_	esidence 6	Other (Spe	clfy)			
〇美籍	ВУ РН		Pending nvestigation	26a. DATE OF (Month, De	INJURY ny, Yonr)	28b. TIM INJ	E OF URY M	WC	URY AT ORK? YES 2		28d. DESCRIBE	E HOW INJU	URY OCCUI	RED	
0 5 4 5 .	<u>.</u>	3 Sulcide 6 🗆	Could not be	28e, PLACE Of building,	F INJURY — At ho etc. (Specify)	me, ferm, s	street, fact	ory, offic	a .		261. LOCATION City or Tow	(Street and m, State)	Number or	Rural Route	n Number,
DIVISION ATTENION DIRECTOR: hours after	9	29a. CERTIFIER 1 C. OFOTT	IFYING PHYSIC	CIAN: To the best of	mu knowleden de							200			
		(Check only one) 2 MEDI	CAL EXAMINE	: On the beals of as	camination and/or	investigatio	n, in my o	me, cera pinion, d	and place	, and dua t red at the ti	o lhe cause(s) lme, data and s	and manne place, and d	r as stated. fue to the c	euse(a) en	nd manner as stated.
FUN With	E	29b. SIGNATURE AND TITLE			10	/				ENSE NUME					ogh, Day, Yearly
TO THE HOSPITAL TO THE FUNERAL BE filed within 72	18			2011	NY	in			1	117	549	7	>	5/	12/75
	10	30. NAME AND ADDRESS OF		COMPLETED CAUS	E OF DEATH (ITE	3				. /	n wer	1	1.0	7	
		21 DATE EN ED ALTER	m	1414	-8 4r		77		1	40	v men	7	W	W	
		31. DATE FILED (Month, Day,)	5 100E	32. REGISTRA	S SIGNATURE	10									
		MAY 1	0 (33)	1	our sy	WAR.	K.								

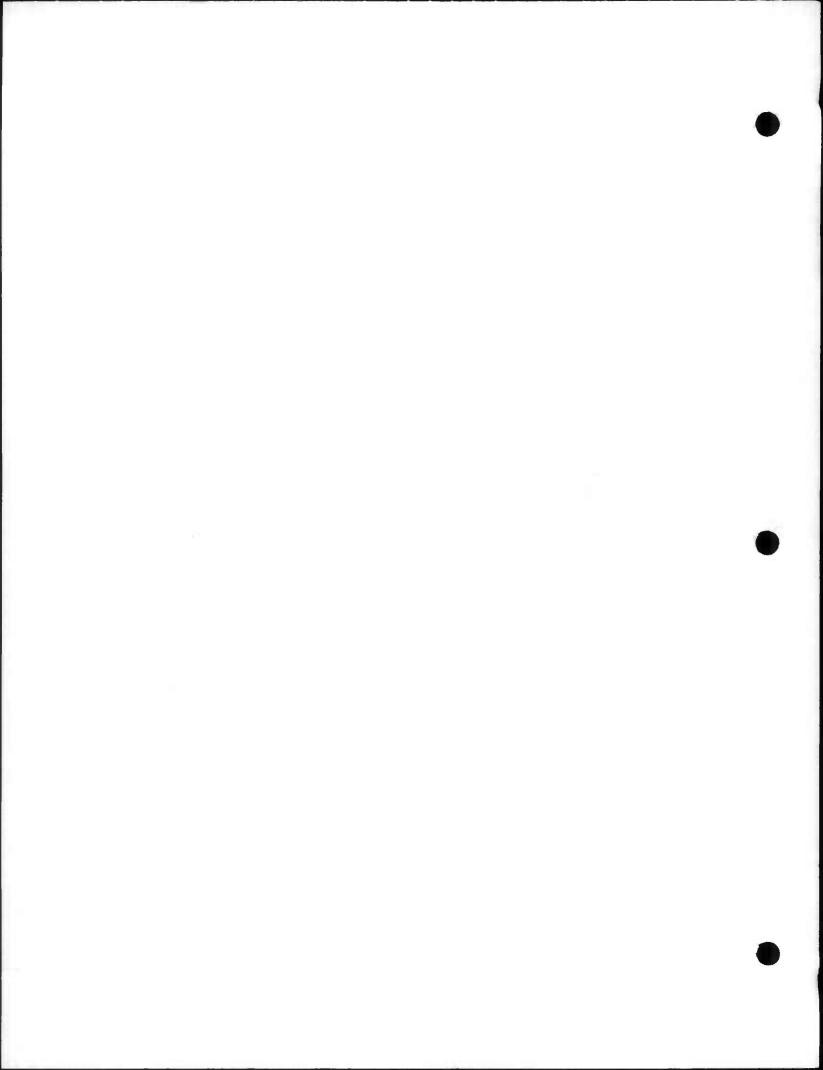


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HUSPITAL UR ALTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1.		
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MILDIN	npletely	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
кесптеа	and cor	burial,	
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	1 - STATE REGISTRAR			TMENT OF ICATE OF		MENTAL HYGIEN REG. NO		
- B	t. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH	AY YEA	3. TIME OF OEATH
ľ		ouglas Murray i. SEX 6. AGE (In yrs.		IF UNDER 1 YEAR	1	May 10,	1995	9:00 р.м
	219-12-1606	X) м 2 □ F 71	YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	July 31,1	.923 Ma	eryland
TOR	90. FACILITY NAME (If not institution, give stree Frederick Memoria			Frede	on Location of Di erick	EATH	Frede	
DIRECTOR	100. STATE 10b. COUNTY Maryland Frede	erick		v, town on Loca ederick	ATION			10d. INSIDE CITY LIMITS?
ERAL	100. STREET AND NUMBER 5011 Teen Barne	es Road		10	21702		U.S.A	OF WHAT COUNTRY?
DI TON	1 News Harded 2 V Harded	2. WAS DECEDENT EVER IN U.S. FORCES? 1 (A) YES 2 [IF YES, GIVE WAR OR DATES AT 6, 1945 Oct. 1	NO	II vee, p		HC ORIGIN? (Specify Yes n, Puerto Rican, etc.)		RACE — Americen Indien, Black, White, etc. SpecifyWhite
PLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementery/Secondary (0-12)	mpleted) College (1-4 or 5+)	DECEDENT'S (Give kind of ville). Do NOT us Carper		ION post of working	16b. KIND OF BU	siness/industruction	37
SE COMPL	17. FATHER'S NAME (First, Middle, Last) Harry Orme				Margu		COL	
TOB	Mrs. Betty M. Murr	ray	196, MAILING 5011	ADDRESS (Street Leen Bar	end Number or Rural I	, Frederic	ck, Md.	21702
	20a, METHOD OF OISPOSITION t K Burlal 2 Cremetlon 3 Remova 4 Donetlon 5 Other (Specify)	20b.PLAC	E AND DATE (commatory or of LOTINE(of disposition (A	ery May	DATE 200. LO	Jeffers	son, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	0255	Z2. NAME A	ney and B	asford P.A	. Fune	ral Home c, Md. 21701
	IMMEDIATE CALIGE (Final	SQVAMOVS DUE TO (OR AS A CONS	ne. CELL	LUNG			iratory arreat,	Approximate Interval Between Onset and Death
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS						
: MEDICAL C	PART II. Other algnificent conditions of					PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 SANO
SICIAN:	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ONTRIBUTE TO CA	03E OI		YES NO			
PHYS	t VES 2 NO 1	Inpellent 2 ER/Outpatient 28e. DATE OF INJURY	3 DOA	4 - Nursing Ho	me 5 Residence	6 Other (Specify) 26d. DESCRIBE HOW I	IN ILION OCCUBE	0
ВУ Р	Netural 5 Pending Accident Investigation	(Month, Day, Year) 26e. PLACE OF INJURY — At	INJ	M 1	YES 2 NO			
ETH	3 Suicide 6 Could not be 4 Homicide determined	building, atc. (Specify)		sireet, rectory, orn		281. LOCATION (Street City or Town, Stete)	end Number of Pil	irai ricule kumber,
7		AN: To the best of my knowledge, On the basis of exemination end/o						ise(s) end menner ee stated.
OM		0111	7	4	29c. LICENSE NUI		29d. DATE SIG	NED (Month Day Word)
O BE COMPLET	29b. SIGNATURE AND TITLE OF CERTIFIER	Brand H	Brod	ans		1761	D 5/	11/95
	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C BRIAN M. B(C) 31. DATE FILED (Month, Day, Year)	COMPLETED CAUSE OF DEATH (I'S NICK 50)	W. SE	Print)	03		1 5/	11/95



	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN	E			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3. TIME OF DEATN		
1.			MAGAHA	Sr		May 8,	1995	1:40 am M		
	4. SOCIAL SECURITY NUMBER 212-14-6881			ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Aug 30, 1	O11 Coun	NPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give atm	R LOCATION OF DE		9c. COUNTY OF	rýland					
18	Frederick Healtho				erick	SIII	Frede			
١٤	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40. 0174	10c, CITY, TOWN OR LOCATION						
DIRECTOR	1.000.000.000	lerick	10c. CITY,	Knoxvi				10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	2124-A Jefferson	Pike			21758	-	U.S	S.A.		
E	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	If yes, spe	city Cuban, Mexican	C ORIGIN? (Specify Yea , Puerto Rican, etc.)	or No- 14. RAC Black	E — American Indian, ck, White, etc.		
B	3 🔀 Widowed 4 🗌 Divorced	5/12/1941-9/	730/1945	1 TYES	2 XNO Specify.		Spe	white		
윤	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	16a, DECEDENT'S US	k done during mos	N et al wadding	166. KIND OF BUS	INESS/INDUSTRY			
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	iii. Do NOT use I	retired.)	. or worlding	Milk T	ransport	ation		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		TLUCK	DIIVEL	18 MOTHER'S NAS	IE (First, Middle, Maiden		acion		
BE C	Leroy		MAG	AHA	Nellie	NE (FIISC, MIDDIN, MINDOIT	Surname)	AHALT		
10 B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street ar	nd Number or Rural R	oute Number, City or Town	n, State, Zip Code)			
-	Harry L. Magaha,					, Knoxvill				
	20a. METNOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Remon	val from State come	PLACEAND DATE OF	r olegoi		OATE 200. LO	CATION — City or T			
	21. SIGNATURE OF BONERAL SERVICE LICE	NSEE //	. OIIVEL	22, NAME AN	D ADDRESS OF FAC	ILITY				
	Heith hom	Roberson	M00706			ord P.A. F				
	23. PART 1. Enter the dispesses, or co	emplications that caused	the death. Do not	enter the mod	ASE Churce of dying, such	ch St. Fre	metory arrest,	Approximate		
	shock, or heert fallure. L. IMMEDIATE CAUSE (Finel	ist only one cause on ea	Λ	0		0 -		Interval Between Onset and Death		
	disease or condition resulting in death)	Cerel		tirens	n de	endut		24 hm		
_		DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	OUE TO (OR AS A	CONSEQUENCE OF):							
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE OF:							
E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF);					i 1		
11 1	DATE II Other elections are distant									
CAL	PART II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying	cause given in F	PERFOR	MED?	b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE		
EDI						1 YES 2	NO	OF DEATH?		
2	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	F DEATH YES	□ NO Ø	UNCERTAIN			1 YES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH							
IXSI		1 Inpatient 2 ER/Oulps	atient 3 DOA 9		5 - Residence					
	Neturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WO		28d. OEŞCRIBE NOW II	JURY OCCURED			
р ву	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Specia	— At home, ferm, stre			28f. LOCATION (Street a	nd Number or Rural	Floute Number,		
	4 Homicide determined	bullaring, etc. (Specia	· y)			City or Town, State)				
COMPLETED		IAN: To the best of my knowle								
S	2 MEDICAL EXAMINER	On the basis of examination	and/or Investigation,	In my opinion, de	ath occured at the I	lme, data and place, en	d due to the ceuse(a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIED	llain	MI		29c. LICENSE NUM	BER		(Month, Day, Year)		
6	30. NAME AND ADDRESS OF PERSON WHO	COMPLATED CAUSE OF DEA	ATH (ITEM 27) (Type. Pr	rint)	D16675		May	6, 1995		
	Dr. Wayne Allgaie				Brunswick	c, Marylan	d 21716			
	31. DATE FILED (Month, Day, Year)	32. REDISTRARIS SIGNA	TURE P	,						
	MAY 1 0 1995	Java ariuse	corrected.							

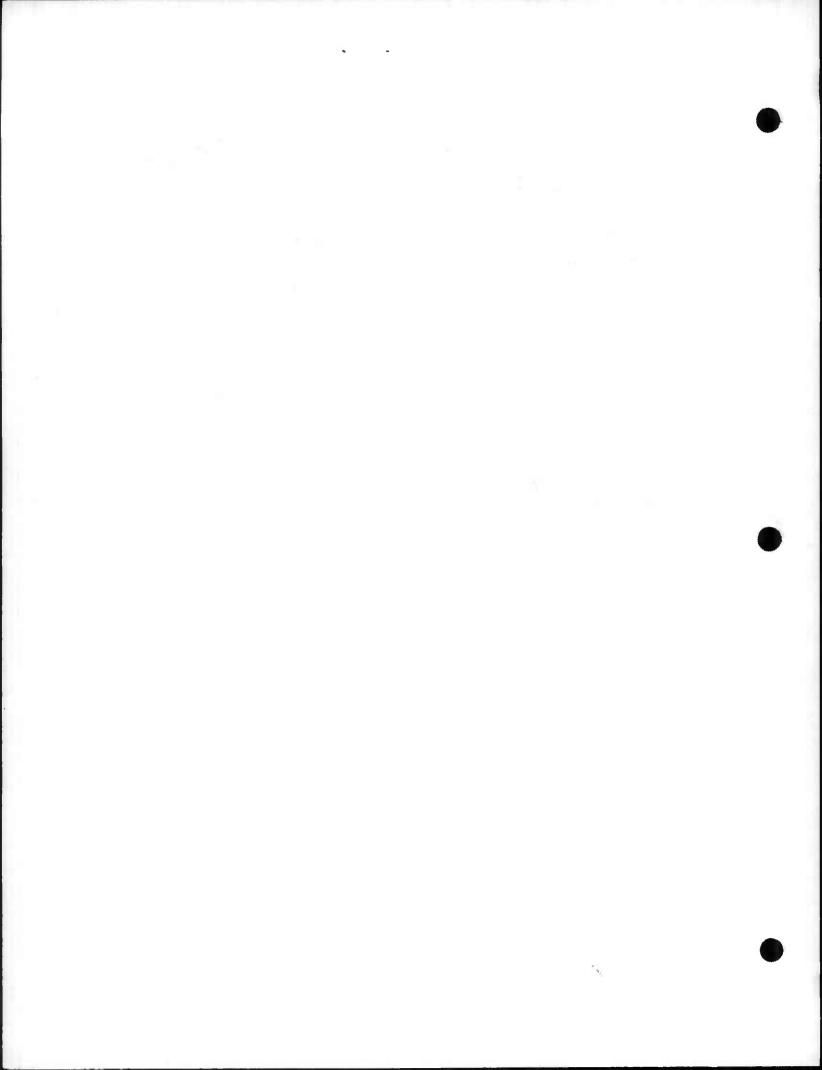


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DIVISION OF VITAL RECORDS,

THE PERSON AND ADMINISTRAL MANAGEMENT OF THE PERSON AND ADMINISTRAL PROPERTY OF THE PERSON AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION ADMINIST
10 THE HOSPITAL OH ALLENDING PHYSICIAN: The law requires that the death certhicate be executed writing a nounce after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMENT OF I	HEALTH AND N	IENTAL HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Lest) Clarissa E.	Marshall			MATE OF DEATH DAY 1995	YEAR 4:00 p M			
В		. SEX 6. AGE (In yrs. le:	st birthday) IF UNDER 1 YEAR YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month, Day, Year)	BIRTHPLACE (State or Foreign Country)			
	9a. FACILITY NAME (If not institution, give atree	t and number)	11 611	OR LOCATION OF DE		TY OF OBATH			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	YLAKC HOSPI	10c. CITY, TOWN OR LOCA	TION	Prince	10d. INSIDE CITY			
L DIF	MARYLAND Char-	es	Waldon	1. ZIP COOE		LIMITS?			
FUNERAL	2549 Mattawa		n Rd	20601	Ц	EN OF WHAT COUNTRY?			
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 H IF YES, GIVE WAR OR DATES	NO If yes, sp	CENDENT OF HISPANI Decify Cuban, Maxican 3 2 10 Specify:	, Puarto Rican, etc.)	14. RACE — American Indian, Black, White, etc. Specify:			
COMPLETED	15. DECEOENT'S EOUCAT (Specify only highest grade con Elementary/Secondary (0-12)	npleted) (G	ECEDENT'S USUAL OCCUPATION When were done during me Do NOT use retired.)	ON ost of working	16b. KIND OF BUSINESS/INDU	STRY			
MPL	12. 17. FATHER'S NAME (First, Middle, Last)	Jonege (1-4 or 5 +)	Maintance		Metropolitan	Cleaning Corp.			
BE CC	Micheal	Granfield		16. MOTHER'S NAM	E (First, Middle, Maiden Surname) Greenfl	eld			
5	Jeffery Marsh	11	304 Potras	and Number or Rural Ro	Alifornia M	20619			
	20a. METHOO OF ISPOSITION 1 Burlal 2 Cremation 3 Ramova 4 Donation 6 Other (Specify)	20b. PLACE comptery, cre	AND DATE OF DISPOSITION (No	ame of	DATE 20c. LOCATION — C	ity or Town, Stata			
	21. SIGNATURE OF FUNERAL SERVICE LICENT			ND ADDRESS OF FAC	hury Majarra	119			
-	23. PART I. Enter the diseases, or com-	pilications-that caused the de	eath. Do not enter the mo	LS Funeral	Home Langs	et, M Z0608			
	shock, or heart fallura. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	e only one cause on each line	D	na M	Stomerah.	interval Batween Onset and Death			
_	DUE TO (OR AS A CONSEQUENCE OF):								
ATIO	Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST								
AL CE	PART ii. Other algnificant conditions c	ontributing to death but not i	resulting in the underlyin	g cause given in P	Part I. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDIC					1 VES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?			
AN: N	DID TOBACCO USE CONTRIB			UNCERTAIN		1 YES 2 NO			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	OSPITAL: Inpetiant 2 - ER/Outpatient 3	OTHER: OTHER: Nursing Horr	ne 5 🗆 Residence 6	☐ Other (Specify)				
	27. MANNER OF DEATH 1. Natural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)		URY AT PRK? YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	JRED .			
red BY	2 Accident investigation 3 Suicide 6 Could not be detarmined	28a. PLACE OF INJURY — At ho building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	29a. CERTIFIER (Check only 1 D CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.								
	2 MEDICAL EXAMINER: 0	In the tale of examination and/or	Investigation, in my opinion, d	eeth occured at the ti	me, data and place, and due to the	cause(a) and manner as stated.			
TO BE	38. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH HTD	- J.S.GIQ	-D 18	328 ▶ 4	1/13/95			
		75018	survey Rd	# 301	1 christin,1	MD 20735			
	MAY 1 5 1995	32. REGISTRAR'S SIGNATURE	Cardall						



DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First) WOODROW		VILSON		MOOR	2F				2. DATE OF DEATH	005	YEAR	3. TIME OF	
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR	IF UNDER 24 I	HDS	7. DATE OF BIRTH	1333	a BIRTH	3:0	
	216-18-5091 1፟፟⊋м₂□ғ			241 121 122	32 YRS.	2 VRS. MONTHS DAYS HOURS MIN. (Month, Dey, Year) May 3, 19			8. BIRTHPLACE (State or Foreign Country) Maryland					
OR	9a. FACILITY NAME (If not institution, give atreet and number) WALDORF HEALTH CARE CENTER					9b. CITY,		LDORF	OF DEA	ATH	9C. COUNTY OF DEATH CHARLES			
5	RESIDENCE OF DEC										CHARLES			
DIRECTOR	10a. STATE	10b. COUNT				Y, TOWN O		TION					10d. INSID	E CITY
	Maryland	Cha	rles			La Pl	ata				1 TES 2 NO			
Z Z	10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY								TRY?					
單	11610 Still	Spri	ngs Place	3				2064	6			US	A	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify) NO If yes, specify Cuben, Mexican, Puerto Rican, etc.)				C ORIGIN? (Specify Yea					
BY	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE Y	WAR OR DATES	Mino	1 Ves. apacity Cuban, Maxican, Puarto Rican, etc.) 1 Ves. 2 No Specify: White					•			
COMPLETED	(Specify onl	EDENT'S EDU y highest grade	completed)		Give kind of	work done di	CUPATIO	ON st of working		16b. KIND OF BUS	SINESS/INC		11200	
12	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)						US Go)	mont		
N	17. FATHER'S NAME (First, M		rora	Foreman US (шепс				
Charalas Tamas Massas								THE STATE OF THE S			,	- ה- וי	~	
19a. INFORMANT'S NAME (Troughton)								S						
일	Effie M. Mo									Place, La			D 206	16
	20a. METHOD OF DISPOSIT	ION		20b. PL A	CE AND DATE	OFDISPOSI	TION /No	me of		DATE 200 100		City or Tox		140
	1 Donation 5 □ Orematic	n 3 🗆 Ram (Specify)	noval from State	cemetery.	cremetory or o	ther place)	ial	Gardei	ne	5-12 Wal				
	21. SIGNATURE OF FURENA	LATERVICE	GENSEE)	1)	in cy i							, 010		
	THE HONT FUNERAL HOME, INC. Mark G. Brohawn M00053 P.O.BOX 156, WALDORF, MARYLAND 20604													
	23. PART I. Enter the di	iseases, or	complications the	t caused the	deeth. Do	not enter t	the mo	de of dying,	, auch	as cardiac or reapl	ratory an	reat,	Appr	roximate
	IMMEDIATE CAUSE (Fir		List only one cau	ise on each i	line.									val Between
	disease or condition resulting in death) a. Duhydration 3 Wics													
	DUE TO (OR AS A CONSEQUENCE OF):													
z	Sequentially list conditions. I a End Stage Multiple Myclama. 5 mas								mas					
CERTIFICATION	Sequentially list conditions, but to (OR AS A CONSEQUENCE OF): Since duentially list conditions, but to (OR AS A CONSEQUENCE OF):													
2	CAUSE (Disease or Inju		С		-		_							
ᄩ	that initiated events resulting in death) LAS	T .	DUE TO	(OR AS A CON	SEQUENCE O	F):								
5			d										_	
	PART ii. Other significa	nt condition	na contributing to	daath but no	ot resulting	In the und	derlying	cause give	n In P	ert i. 24a. WAS AN		24b.	WERE AUTO	PSY FINDINGS
EDICAL										PERFOR	VV		AVAILABLE I	PRIOR TO
										1 YES 24	- NO		OF DEATH?	
2	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF D	FATH YE	SΠN	IO X	UNCER	TAIN	l			1 TES	2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO				LACE OF DEA			OTTOLK	IZIII					
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	: ina Hom	a 5 Reelde	noce 6	Other (Specify)				
È	27. MANNER OF DEATH		28a, DATE OF	INJURY	28b. TIM	E OF	28c. INJ	JRY AT		28d. DESCRIBE HOW IN	JURY OC	CURED		
ВУР		Pending Investigation	(Month, D	ay, rear)	INJ	JURY M		RK? 'ES 2 NO	0					
	2 - 0	Could not be	28e. PLACE O	F INJURY At	home, farm,	street, facto	ry, office		- 2	28f. LOCATION (Street a	nd Number	or Rural R	oute Number	
TED		determined	bullang,	etc. (Specify)						City or Town, State)				
7	29a. CERTIFIER	IFYING PHYS	ICIAN: To the best of	my knowledge	death occurr	ad at the tim		and alone and		o the cause(a) and man	C-16 III			
COMPLET										o the cause(a) and man me, data and place, and			and manni	
	29b, SIGNATUNE MID STILE			- /										
BE	1/1///	1/10	1/1/1/1	1 hr	\circ			29c. LICENSE	E NUMB	ER C			(Month, Day,	
2	30. NAME AND ADDRESS OF	DEBSON WITH	O COMPLETED COM	// //	<u></u>	0.7-0		114	64	الالا	- N	IAY 1	0, 19	95
	Charles	10 A	Luche	n bro	V 0	700	Old	L Line	Ce	ntre Suite	井口	N (X	12/1	et MD
	J. DATE FILED (Month, Day,	5 199	5 Jalia	A SIGNATURE	Redel	2					,,,		× - 1 M/	

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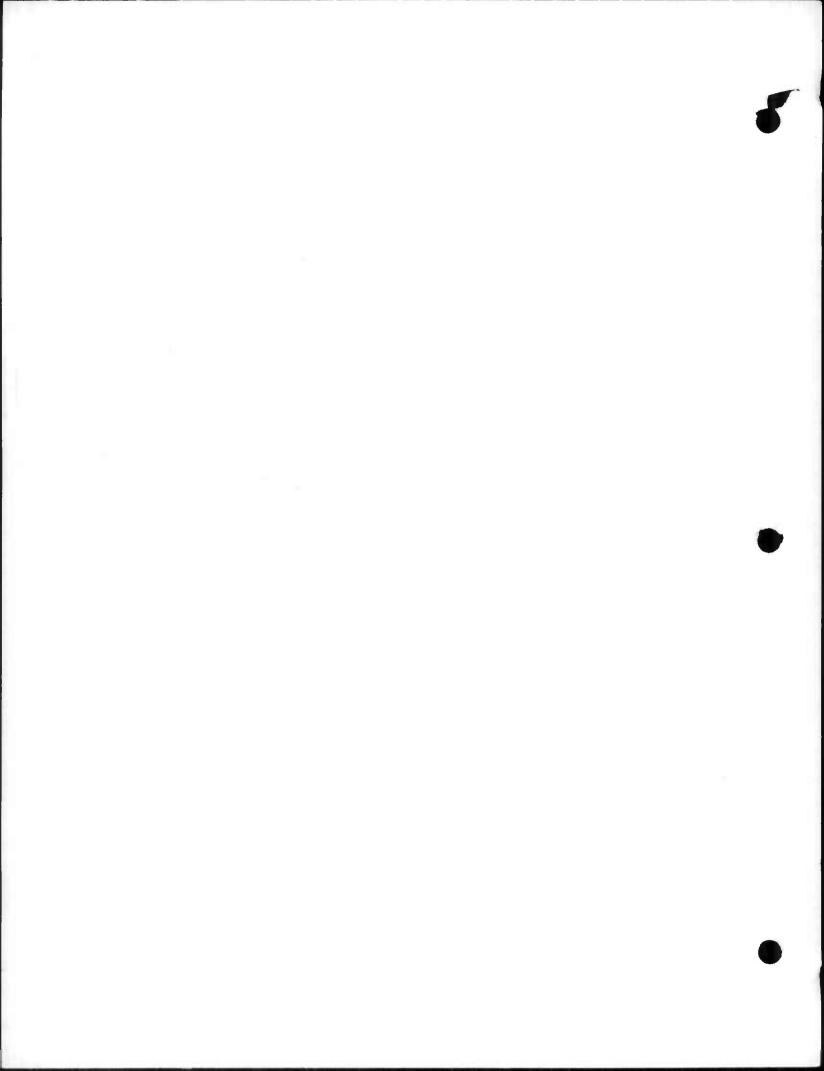
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IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. TIMORE, MARYLAND 21215-0020

	FOR
1	STATE
	REGISTRAR

	REGISTRAR			ERIT	ICALE	: UF	DEATH		REG. NO			
	1. OECEDENT'S NAME (First, Middle, Last)	ę	· .		,			MO	TE OF DEATH	NY .	YEAR	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER						sh.		any c	Carl	47	
	and the second s	5. SEX 1 M 2 K F	3. AGE (In yrs. lea 56	YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAY	TE OF BIRTH brith, Day, Year) 7. 7, 19	38	Country	Virginia
_	9a. FACILITY NAME (If not institution, give stre		9b. CITY,	TOWN	OR LOCATION OF		,, 1.		UNTY OF OE			
DIRECTOR	Holy Cross Hospita	Sil	ver	Spring			Montgomery					
E E	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION					10d. INSIDE CITY LIMITS?
	Maryland Montg	omery		Roo	ckville							1 🖾 YES 2 🗌 NO
FUNERAL	4700 Arbutus Avenu		101. ZIP CODE 20853				10g. CITIZEN OF WHA			HAT COUNTRY?		
F I	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEOENT ! FORCES? 1	EVER IN U.S. AF	J.S. ARMED 13. WAS OECENOENT OF HISPANI 2 2NO 14 yes, specify Cuban, Maxican,			ANIC ORIG	IIC ORIGIN? (Specify Yes or No — 14. RACE -			- American Indian, White, atc.	
8≺	3 Widowed 4 Divorced	OR OATES	1 ☐ YES 2 ☒ NO Specify: Specify:									
邑	15. DECEOENT'S EOUCJ (Specify only highest grade of	16a, DE	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working) 18b. Do NOT use retrieval.)									
COMPLETED	Elementary/Secondary (0-12)	***	Homemaker Own Home									
OM	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden S									
BE C	Otho D. Fink, Sr.						Grace	Lou	dermilk			
2	19a. INFORMANT'S NAME (Type/Print) John Marsh						nd Number or Rura					20052
	20a. METHOO OF DISPOSITION	20b. PLACE	4700 Arbutus Avenue, Rockville, Maryland CEAND DATE 20c. LOCATION — City or Town					n Stete				
	1 N Burial 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	Viev	v Cen	ete	ry	5	5/13 Ronceverte, West Virgi					
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE +	Chr. 014	7 10 6	22.1	NAME AN	New Ha	ACILITY	Hines-R	inal	df Fi	ineral Home
	23. PART i. Enter the disesses, or co	emplications that of	aused the de	eth. Do r	S:	ilve	r Sprin	g, M	aryland	20	904	Approximate
	ehock, or heart fallure. Li iMMEDIATE CAUSE (Final	lst only one cause	on each line).			ac or cymg, so		indisc of respi	atory ar	Test,	Interval Batween Onset and Death
	disease or condition resulting in death) a. Cardiac Crythuia huma OUE TO (OR AS A CONSEQUENCE OF):											
z	Sequentially list conditions b.											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
윤	CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):											
EB	resulting in death) LAST d.											
	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY FINDINGS											
EDICAL	PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE											
Σ	1 ☐ YES 2 NO											
Y Y	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one)											
Sic	EXAMINER?	HOSPITAL:			OTHER	:	5 Residence	6 🗆 Ot	her (Specify)			
PHYSICIAN:	27. MANNER OF OEATH	26a. OATE OF IN (Month, Day,	JURY	26b. TIM		28c. INJ		-	ESCRIBE HOW II	JURY OC	CUREO	
à l	2 Accident Investigation						ES 2 NO					
E	3 Suicide 6 Could not be determined	28e. PLACE OF I building, atd	njunt — At he	me, farm, a	mreet, facto	ery, office	•	281. LC	OCATION (Street a ty or Town, State)	nd Numbe	r or Rural Ro	ute Number,
COMPLETED	29a, CERTIFIER (Check only one) 1 CERTIFYING PHYSICI. 2 MEDICAL EXAMINER:											and manner as stated
ŭ	296. SIGNATURE AND TITLE OF CERTIFIER	^					29c. LICENSE NU			and due to the cause(e) and manner as stated. 29d. DATE SIGNEO (Month, Day, Year)		
10 8	3/4 Dise	well	m	-			208	54	t6	PN	a	10 9T
	30. NAME AND ACCRESS OF PERSON WHO	COMPLETEO CAUSE			Print)	8 1	0) (S) (- A	Siei	A	1 2000	24-1
	31. DATE FILEO (Month, Day, Year)	32. BEGISTRAR'S				~a		-		1.5	.06	Helman
	MAY 19 100E	July As	whenter	.1.11								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

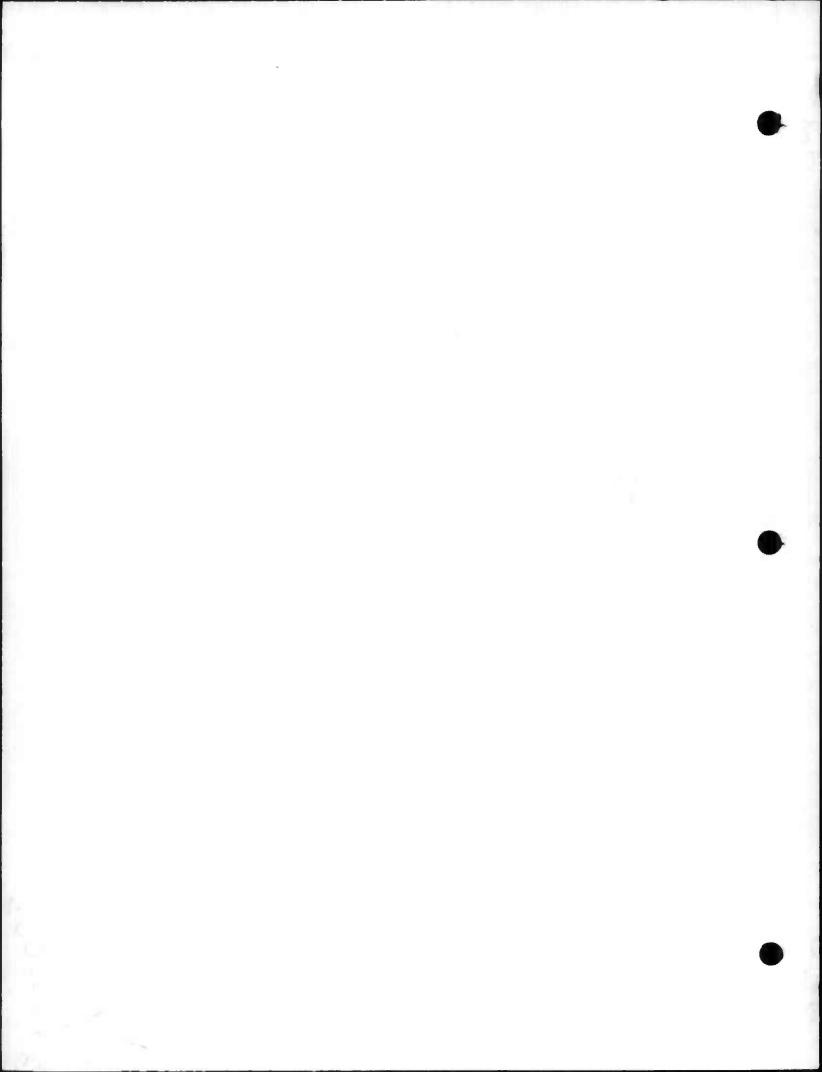
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an individual Page 6 may be retained by the hospital or attending physician.

TO THE HUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

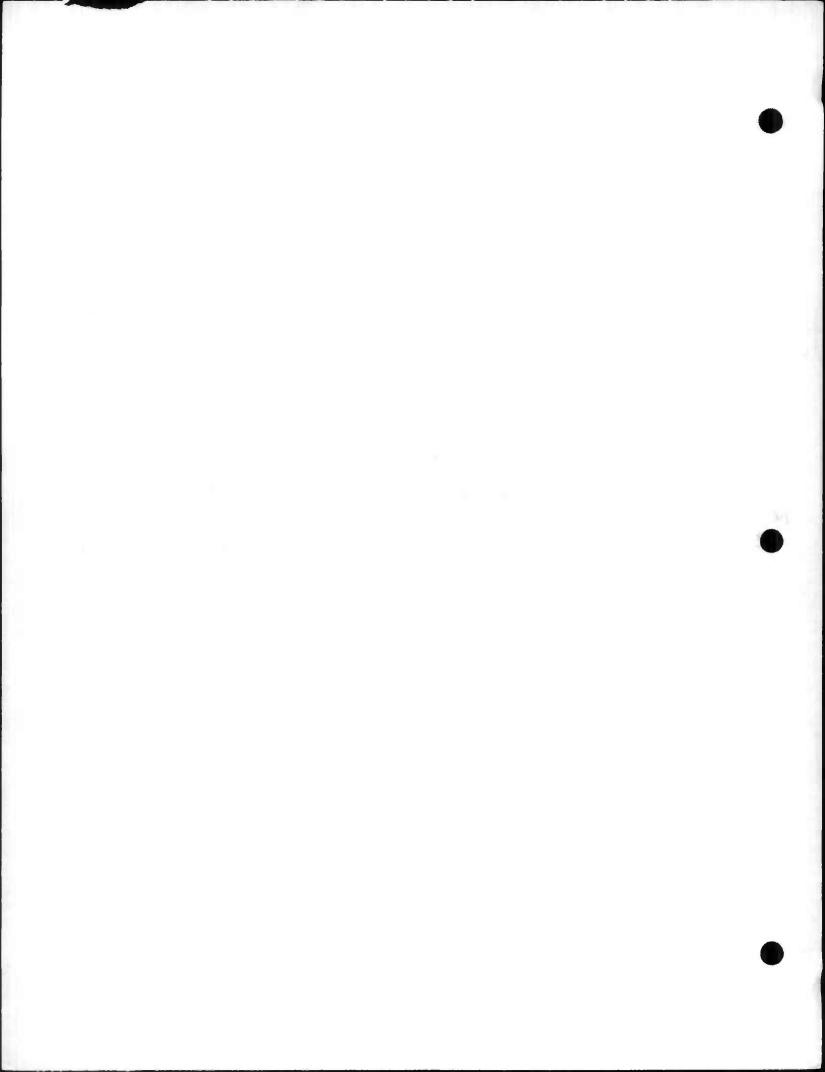
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

1 - FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF	DEATH		T	3. TIME OF DEATH
	REIDUN IRENE M						ILLER				MAY 2, 1995			12:18 A
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER	9 24 HRS.	7. DATE OF	7. DATE OF BIRTH 8. BIRTHP			PLACE (State or Foreign
	578 94 0335		1 🗌 M 2 😾 F	58	YRS.	MONTHS	NTHS DAYS HOURS MMN. (Month, Dey, Year) Country) Feb. 15,1937 Norway							
	9e. FACILITY NAME (If not institution, give street and number)					9b. CITY	b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
OR	THE JOHNS HOPKINS HOSPITAL					BALTIMORE CITY -								
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					Y, TOWN (OR LOCAT	LION						
E	Maryland Montgomery					thes		ion						10d. INSIDE CITY LIMITS?
	10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?										1 YES 2 NO			
FUNERAL	6504 Michaels Drive 20817 United St													
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR										pecify Yee	e or No — 14. RACE — American Indian, Black, White, etc.		
BY F	1 ☐ Never Merried 2 ☑ Merried FORCES? 1 ☐ YES 2 ☑ NIF YES, GIVE WAR OR DATES					If yee, specify Cuben, Mexican, Puerto Rican, etc.) Black					Black, Specify			
	1040	1717												White
COMPLETED	(Specify only	highest grade	completed)		Give kind of a	work done	CCUPATIO	ON ast of working	ng	16b. KIN	D OF BUS	INESS/INC	USTRY	
PLE	Elementary/Secondery (0	-12)	College (1-4 or 5	+) ""		ind of work done during most of working NOT use relined.) Omemaker Own Home								
OM	17. FATHER'S NAME (First, M	iddle, (.ast)				Own Home 18. MOTHER'S NAME (First, Middle, Meiden Surmeme								
ш	Martin Rav	nanger								ohanne		ournemoy.		
TO B	19e. INFORMANT'S NAME (7	/pa/Print)		1	9b. MAILING	ADDRESS	(Street e	nd Number	or Rural F	Route Number, (City or Town	, State, Zip	Code)	
F	Ralph L. Mi	ller,	Jr.		6504	Mich	aels	Dri	ve,	Bethes	da,	MD 2	0817	
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of M a 77 6 1 0 0 NTE 20c. LOCATION — City or Town, State													
Connetery, Cremetory or biner place)									kvil	ville, Maryland				
									ey_Funeral					
	15	117	that)	M006		Wi	scor	sin	Aven	ue, Be	thes	da,	MD 20	814-3501
	23. PART/I. Imper/use di	seeses, or c	omplications the	t caused the d	lesth. Do r	not enter	the mo	ds of dy	ing, suci	n ss cardlec	or respli	ratory srr	est,	Approximate Interval Between
	IMMEDIATEVEXUSE (Finel													
	resulting in death) SCPSIS DUE TO (OR AS A CONSEQUENCE OF):													
_														
ğ	Sequentially liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury. CAUSE (Disease or injury.													
3	cause. Enter UNDERLYING CAUSE (Disease or injury a end stage liver disease													
CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
Ä	resulting in deeth) LAST													
	PART ii. Other algnifice	nt condition	e contributing to	deeth but not	resulting i	in the un	derlying	ceuse g	given in	Part I. 24s	. WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS
MEDICAL											AWAILABLE PRIOR TO COMPLETION OF CAUSE			
ij.										_ ' '] 120 1	NO.		F DEATH?
	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆 I	10 E	UNC	ERTAIN	10				
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER?													
YSI	1 TES 2 NO		1 Inpetient 2		3 🗆 DOA	OTHER		e 5 □ Re	sidence	6 Other (Sp	ecify)			
	27. MANNER OF DEATH	Pending	26e. DATE OF (Month, D		26b. TIM	E OF URY		RIC?		28d. DESCRI	BE HOW IN	JURY OCC	URED	
B	2 Accident	nveetigation	200 BLACE O	E IN HIEV ALL		M		/ES 2	NO					
9		Could not be letermined	building,	F INJURY — At hetc. (Specify)	ome, term, s	treet, tect	ory, office			26t. LOCATIO City or To	N (Street al wn, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	29e. CERTIFIER													
MP	(Check only		CIAN: To the best of a											
8				Carrianaerorr eng/or	Investigatio	n, in my o	pinion, a				place, end	due to the	e cause(e)	and menner es stated.
BE	296 STONATURE AND TITLE	CERTIFIER	n mp					2.0	NSE NUM	BER		29d. DATE	SIGNEO (Ageth, Day, Year)
2	39 HAND AGORESS OF	PERSON WHO		SE OF DEATH //T	M 271 /5m-	Princt		fr.	024	7			12/	7.5
	(Tun) M	PHERSI		6000	1. WO	LFE	57.	Tou	I=P I	n Br	9677	MO	ee.	MP 21287
	31. DATE FILED (Month, Day,	bar)					/	010	41	N/			- (21691
	MAY 08	1995	Julia Dan	R'S SIGNATURE	all									



	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAL HYGIEN REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Francis Brandis	Marsh				May 9, 19		4:55 A.	м	
	4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreig		
	214-30-0840	□ M 2 万 F 8	39 YRS. "	IONTHS DAYS	HOURS MIN.	(Month, Day, Year) May 17, 1		Country) North Caroli		
	9s. FACILITY NAME (If not institution, give street	t and number)		96. CITY, TOWN	OR LOCATION OF D			TY OF DEATH	ıa	
OR	5419 Goldsboro Ro	ad		Bethe	sda		Mont	gomery		
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		40- 0071	TOWN OR LOCA						
DIRECTOR					ION		10d. INSIDE CITY LIMITS?			
	Maryland Montg	omery	Bet	hesda	. ZIP CODE		T 40- OFFITT	1 TES 2 NO		
FUNERAL	5419 Goldsboro Ro	ad		1"	20817	10g. CITIZEN OF WHAT COUNTRY?				
Ñ		2. WAS DECEDENT EVER IN (U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	U.S.A. or No. 14. RACE — American Indian,				
	1 Never Married 2 Married	FORCES? 1 YES		If yes, sp	ecity Cuban, Mexica 2 NO Specif	in, Puerto Rican, etc.)		Black, White, etc. Specify:		
ВУ	3 X Widowed 4 Divorced					,		White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION npleted)	(Give kind of wo	rk rinne rivring me	ON st of working	16b. KIND OF BUS	BINESS/INDU	STRY		
٦	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	He. Do NOT use Educa			Educa	tion			
M	17, FATHER'S NAME (First, Middle, Last)	3 ⊤	Educa	LOI						
ŏ	Henry Parker Brand	lic			A STATE OF THE STA	ME (First, Middle, Meiden kie Dorgan				
BE	19a. INFORMANT'S NAME (Type/Print)	113	19h MAILINO A	DDBESS /Street		Route Number, City or Tow		Name of the second		
2	Henry Brandis Mars	:h				evy Chase,				
	20a. METHOD OF DISPOSITION	20b. P	LACE AND DATE OF	DISPOSITION (Na	nme of			ty or Town, State	\dashv	
	1 X Burial 2 Cremation 3 Removal 4 Donation 6 Other (Specify)	from State cemete	ery, crematory or other	ill Cem	etery	5/16 Sal	isbur	y, NC		
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME A	ND ADDRESS OF FA	CUTY Joseph (Gawler	's Sons, Inc		
	> Veina)	Sinma		12120 4	visconsi	n Avenue, 1 .C. 20016	V.W.	,		
	23. PART I. Enter the diseesea, or com	pilostions that coused t	the deeth. Do no	t enter the mo	de of dying, auc	h as cardiac or reepi	ratory arres	at, Approximata		
	ahock, or heart fallure. Liet IMMEDIATE CAUSE (Final	t only one cause on eac	th line.					Interval Betw Onset and De		
	disease or condition resulting in death)	In death) To the A Color of the A Co							2,	
	(A)	DUE TO (OR AS A C	ONSEQUENCE OF):							
NO	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
TA!	If any, leading to immediate cause. Enter UNDERLYING									
E	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	resulting in daeth) LAST									
	PART II. Other algnificent conditions c	contribution to death but	not resulting to	AND CODE LAIRS	e i escoco CH. In					
CAL	ANT II. Other aignincent conditions c	ontributing to deeth but	not resulting in	the underlyin	g ceuse given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDIF AMAILABLE PRIOR TO		
ā						4 FT VEC A	NO	OF DEATH?	E	
ш						I TES 2	\wedge	OI DEAIN!		
: ME	DID TORACCO LISE CONTRIB	LITE TO CALISE OF	DEATH VEC	D NO B	LINICEDTAN	/	\wedge	1 YES 2 NO		
IAN: ME	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAIL	/				
SICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26 OSPITAL:	PLACE OF DEATH	(Check only ofe)		N D				
HYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH	26 OSPITAL: Inpetient 2 ER/Outpeti	PLACE OF DEATH	(Check only out) OTHER: Nursing Hom OF 28c. INJ	e 5 Residence	/	NJURY OCCU	1 YES 2 NO		
Y PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26 OSPITAL: Inpetient 2 ER/Outpet	PLACE OF DEATH	(Check only over) OTHER: Nursing Hom OF 28c. INJ	e 5 Residence	N Other (Specify)	NJURY OCCU	1 YES 2 NO		
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	26 OSPITAL: Inpetient 2 ER/Outpeti	lent 3 DOA 4 28b. TIME INJUF	(Check only ode) OTHER: Nursing Hom OF 28c. INJ Y M 1	e 5 Residence URY AT RIGT (ES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW III 28t. LOCATION (Street a		1 YES 2 NO		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	28 DATE OF INJURY (Month, Day, Year)	lent 3 DOA 4 28b. TIME INJUF	(Check only ode) OTHER: Nursing Hom OF 28c. INJ Y M 1	e 5 Residence URY AT RIGT (ES 2 NO	N ☐ Other (Specify) 2ed. DESCRIBE HOW II		1 YES 2 NO		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFYINO PHYSICIAL	28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY building, stc. (Specify,	PLACE OF DEATH Indextor Indextor Indextor	(Check only ode) OTHER: Nursing Hom OF XY M 1 1 1	e 5 Residence usy AT RKY (ES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State)	and Number or	1 YES 2 NO		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFYINO PHYSICIAL	28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY building, stc. (Specify,	PLACE OF DEATH Indextor Indextor Indextor	(Check only ode) OTHER: Nursing Hom OF XY M 1 1 1	e 5 Residence usy AT RKY (ES 2 NO	6 Other (Specify) 28d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State)	and Number or	1 YES 2 NO	d.	
COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFYINO PHYSICIAL	28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY building, stc. (Specify,	PLACE OF DEATH Indextor Indextor Indextor	(Check only ode) OTHER: Nursing Hom OF XY M 1 1 1	e 5 Rasidence URY AT RIVY (ES 2 NO and place, and dua esth occured at the 29c. LICENSE NUM	5 Other (Specify) 26d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, an	and Number or oner as stated d due to the	1 YES 2 NO	d.	
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. DATE OF INJURY	At home, farm, stri	(Check only ofe) OTHER: Nursing Hom OF Y M 1 set, factory, office at the time, data in my opinion, d	e 5 Residence URY AT RES 2 NO and place, and due esth occured at the	5 Other (Specify) 26d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, an	and Number or oner as stated d due to the	1 YES 2 NO	d.	
COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	OSPITAL: Inputert 2 ER/Output 28a. DATE OF INJURY 28a. PLACE OF INJURY 28a. PLACE OF INJURY building, stc. (Specify, N: To the bast of my knowled on the basis of axamination a	At home, farm, str.) At home, farm, str.) At home, farm, str.) At home, farm, str.) At home, farm, str.) At home, farm, str.) At home, farm, str.)	(Check only ofe) OTHER: Nursing Hom OF AV Nursing Hom OF AV Nursing Hom Off 1	e 5 Rasidence usy AT RIVI (ES 2 NO and place, and dua esth occured at the 29c. LICENSE NUM	8 Other (Specify) 28d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, and #BER	oner as stated d due to the company DATE 5	1 YES 2 NO REO Rural Route Number, cause(s) and manner as states SIGNED (Month, Day, Year)	d.	
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	OSPITAL: Inpettent 2 ER/Outpett 28a. DATE OF INJURY 28a. PLACE OF INJURY building, stc. (Specify, or the basis of axamination at the basis of axamination a	At home, farm, str. At home,	(Check only ofe) OTHER: Nursing Hom OF AV Nursing Hom OF AV Nursing Hom Off 1	e 5 Rasidence usy AT RIVI (ES 2 NO and place, and dua esth occured at the 29c. LICENSE NUM	5 Other (Specify) 26d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, an	oner as stated d due to the company DATE 5	1 YES 2 NO REO Rural Route Number, cause(s) and manner as states SIGNED (Month, Day, Year)	d.	
BE COMPLETED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	OSPITAL: Inputert 2 ER/Output 28a. DATE OF INJURY 28a. PLACE OF INJURY 28a. PLACE OF INJURY building, stc. (Specify, building, stc. (Spe	At home, farm, stri	(Check only ofe) OTHER: Nursing Hom OF AV Nursing Hom OF AV Nursing Hom Off 1	e 5 Rasidence usy AT RIVI (ES 2 NO and place, and dua esth occured at the 29c. LICENSE NUM	8 Other (Specify) 28d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State) to the cause(a) and man time, data and place, and #BER	oner as stated d due to the company DATE 5	1 YES 2 NO REO Rural Route Number, cause(s) and manner as states SIGNED (Month, Day, Year)	d.	



3. TIME OF DEATH

6:36

10d. INSIDE CITY

8. BIRTHPLACE (State or Foreign

Canada

Montgomery

9c. COUNTY OF DEATH

P

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Mary J. Mario May 9, 1995 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2XX 022-05-6504 YRS. 83 Dec. 1,1911 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Manor Care-Potomac Potomac RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Potomac 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 8108 Coach Street be detached for use as the burial-transit 20854 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Ri 1 YES 2 XNO Specify BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 6 Shipping Inspector 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Joseph Hennessey BE Mary Ann MacKinnon notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Ronald J. Mario 8108 Coach Street, Potomac, Maryland hours after death. Page 6 may be 2 20b. PLACE AND DATE OF DISPOSITION (Name of 12, 1995 METHOD OF DISPOSITION
Burlal 2 Cremation 3 Removal from State must DATE St. Joseph Cemetery 4 Donation 6 Other (Specify) examiner 21. SENATURE OF FUNERAL SERVICE LICENSEE ulla M00348 and completely filled in by the oburial, cremation, or removal. medical 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Our shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition . Aspiration Pneumonitis, Both Lungs resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) Multi-Infarct Dementia CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 the attending physician Mental Hygiene prior to if any, leading to immediate the death certificate be cause, Enter UNDERLYING CAUSE (Disease or Injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL Health and requires that ашу been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \boxtimes UNCERTAIN \square PHYSICIAN: HOSPITAL DR ATTENDING PHYSICIAN: The law FUNERAL DIRECTOR: After this certificate has bo within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER 1 TES 2XXNO Inpetient 2 - ER/Outpetient 3 - DOA 4 X Nursing Home 6 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF 26c. INJURY AT WORK? 1X Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 90 3 Suicide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE attending Physician Soll nun D18084

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE

Dineshbhai Patel, M.D.,

MAY 11 1995

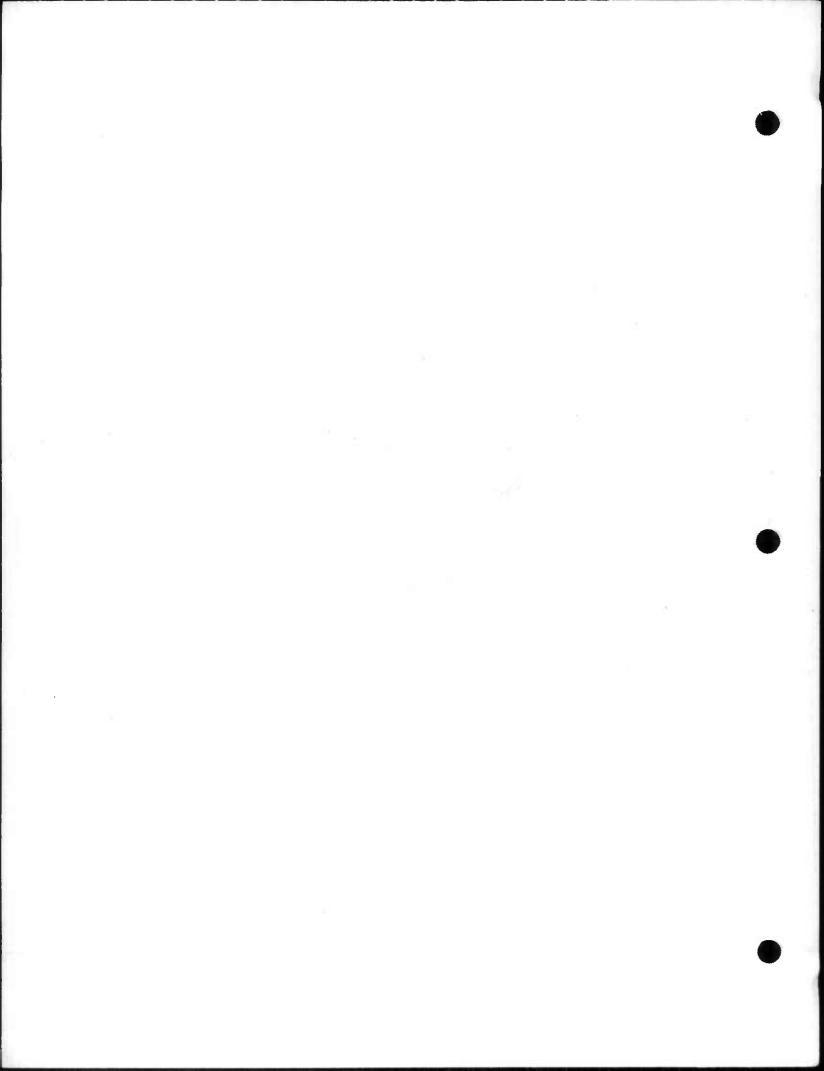
31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1 YES 2 X NO 10g, CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, stc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Screw Manufacturing 20854 20c. LOCATION - City or Town, State Keene, New Hampshire 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501 Interval Betw Onset and Death 1 day 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 X NO OF DEATH? 1 TES 2 X NO 26d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d, DATE SIGNED (Month, Day, Year) May 9, 1995 6121 Montrose Road, Rockville, Maryland DHMH-16 Rev 1/89

2



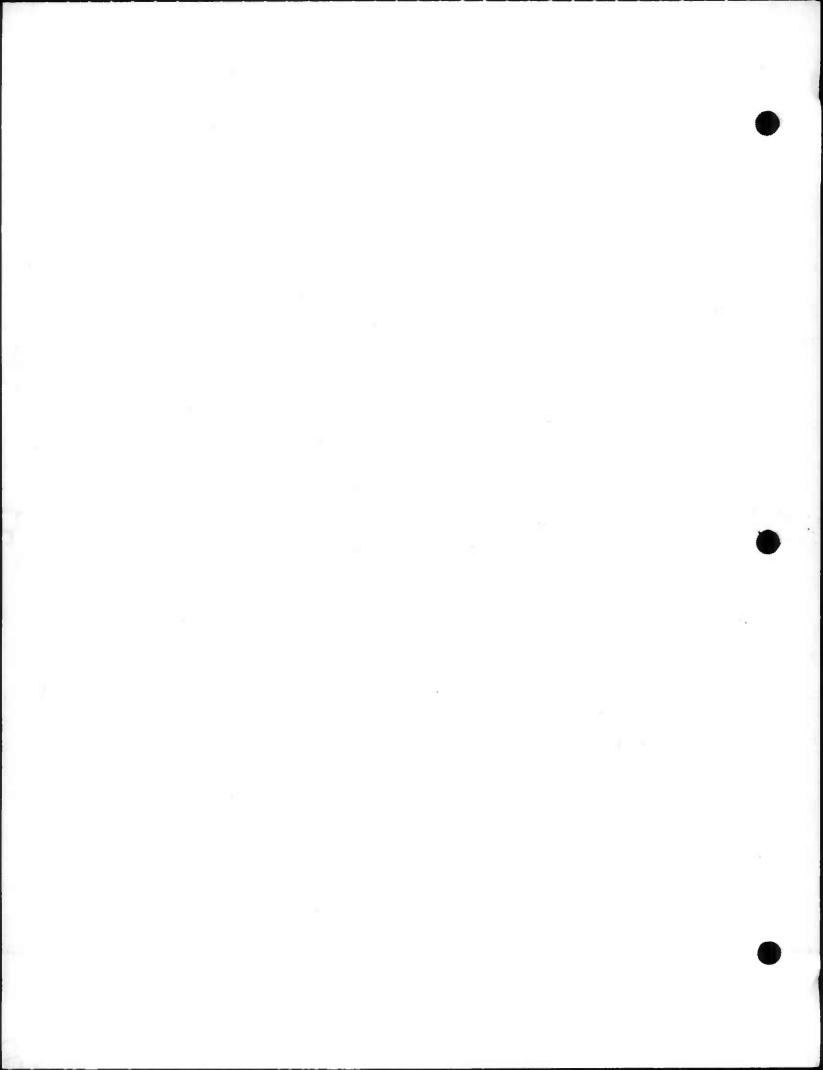
R	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing From siter death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
	TO THE HOSPITAL OR	TO THE FUNERAL DIRI	be filed within 72 hour	IMPORTANT: If Item	

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

REGISTRAR		CERTIFIC	CATE O	F DEATH	RE	G. NO.		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		3. TIME OF DEATH
Victori	a Dejter M	larkle			May 8,	1995	YEAR	9:14 P
4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIT		I a BIOT	HPLACE (State or Foreign
210 48 1170	1 M 2 K F		ONTHE DAYS		(Month Day	Year!	Coun	(ry)
219-48-1170					July 9	,1963	Was	hington, DC
9a. FACILITY NAME (If not institution, give s		9		OR LOCATION OF D	EATH	9c. COL	UNTY OF	
Suburban Hospital			Bet	hesda			Mor	ntgomery
RESIDENCE OF DECEDENT								
10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOC	ATION				10d. INSIDE CITY LIMITS?
Maryland	Montgomery		Ken	sington				1 TYES 2 X NO
10e. STREET AND NUMBER			T.	IOI. ZIP CODE		10a CI	TIZEN OF	WHAT COUNTRY?
4304 Matthews Lan	10			20895	:	-		States
11. MARITAL STATUS							. Lea	States
1 Never Married 2 Married	12. WAS DECEMENT EN		13. WAS DI	ECENDENT OF HISPA specify Cuban, Maxico	NIC ORIGIN? (Spe	cify Yea or No-	14. RAC	E — American Indian, ck, Whita, atc.
3 Wildowed 4 Divorced	IF YES, GIVE WAR		1 🗆 Y	S 2 NO Specif	y:	etc.)	Spec	
3 Wildwed 4 Divorced								White
15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S US	UAL OCCUPAT	TION	16b, KIND	OF BUSINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	k done during r retired.)	nost of working				
_	4	Home	maker			Own Hom	16	
17. FATHER'S NAME (First, Middle, Last)	-	110.110.			ten con and			
	D = 2.1			18. MOTHER'S NA				
Stephen W.	Dejter					. McKen		
19a. INFORMANT'S NAME (Type/Print)				t and Number or Rural				
Timothy S. Markle		4304 M	atthew	s Lane, k	Kensingt	on, Mar	ylar	d 20895
20a. METNOD OF DISPOSITION		20b. PLACE AND DATE OF	DISPOSITION	Neme of	CATE	20c. LOCATION —	City or T	num State
tX Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	20b. PLACE AND DATE OF cemetery, cremetory or other	plece) Ma	y 12, 199	5 715			
		Gate of He				Silver S	prir	g,Maryland
21. SIGNATURE OF EUNERAL SERVICE LIC	CENSEE		22. NAME	AND ADORESS OF FA	Robe	rt A. P	umph	rey Funeral
X /-0. C	14		Home/	Bethesda-	-Chevy C	chase, I	nc.,	7557
23. PART I. Enter the diseases, or.	Jours	M00202	Wisco	nsin Ave.	, Betne	esda, ML	208	314-3501
iMMEDIATE CAUSE (Final disease or condition rasulting in death)		atic Carcino	oid					Onset and Death
Sequentially list conditions,	b. DUE TO (OR	AS A CONSEQUENCE OF);						
If any, leading to immediate cause. Enter UNDERLYING		in it deliberated or j.						i
CAUSE (Disease or injury	C. DUE TO COR	AS A CONSEQUENCE OF):						
that initiated events resulting in death) LAST	DOE TO (OR	AS A CONSEQUENCE OF):						
	d							
PART II Other significant conducts	a a a a dell	41.1.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.						
PART II. Other algolificent condition	contributing to dea	ith but not resulting in	the underlyl	ng ceuse given in		MAS AN AUTOPSY PERFORMED?	248	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
						YES 2 NO		COMPLETION OF CAUSE
4					' ' '	- 100		OF DEATH?
DID TOPACCO LISE CONT	DIDLITE TO CALIC	E OF DEATH VEC		7 11510000000				1 TYES 2 NO
DID TOBACCO USE CONT	KIBUTE TO CAUS				N L L			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH		9)				
1 TES ZA NO	1 N Inpetient 2 ER		THER: Nursing No	me 5 🗆 Residenca	6 Other (Spec	ity)		
27. MANNER OF DEATH	28a. DATE OF INJU	JRY 28b. TIME C	OF 28c, IP	NJURY AT		NOW INJURY OC	CURED	
1XXNatural 5 Pending	(Month, Day, Y	bar) INJUR	Y	YES 2 NO				
2 Accident Investigation	260 PLACE OF 11	HIRV At he to			20.00			
3 Suicide 6 Could not be 4 Nomicide datarmined	building, etc.	JURY — At home, term, stre (Specify)	wt, tactory, off	ICE	26t. LOCATION City or Town	(Street and Number, State)	or Aural	Route Number,
Detilinand								
29a. CERTIFIER 1X CERTIFYING PHYSI	CIAN: To the best of my	knowledge, death occurred a	of the time de	le and place and du-	to the serie (a)	-MILTON	100	
	JI THE GUARA OF ANAMA	nation and/or investigation,	my opinion,	own occured at the	iime, date and pl	ace, and due to t	he cause(a) and manner as stated.
296. SIGNATURE AND TITLE SE CHITIFIE	1/1			29c. LICENSE NUI	MBER	29d. DAT	TE SIGNED	(Month, Day, Year)
1/4	houth	>		D22086	1.000			10, 1995
30. NAME AND AODRESS OF PERSON WN	O COMPLETED CAUSE O	E DEATH //TEM AT ~	(-1)	D22000	,		ray	101 1000
				N 57 57	-1-2 ·	- 50	2000	-
Frederick P. Smit	n, M.D., 5	401 Western	Ave.,	N.W., Wa	asningto	on, DC	2001	.5
31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S							
MAY 11 1991	· 1 1.1. As.	Ober Ranfall						



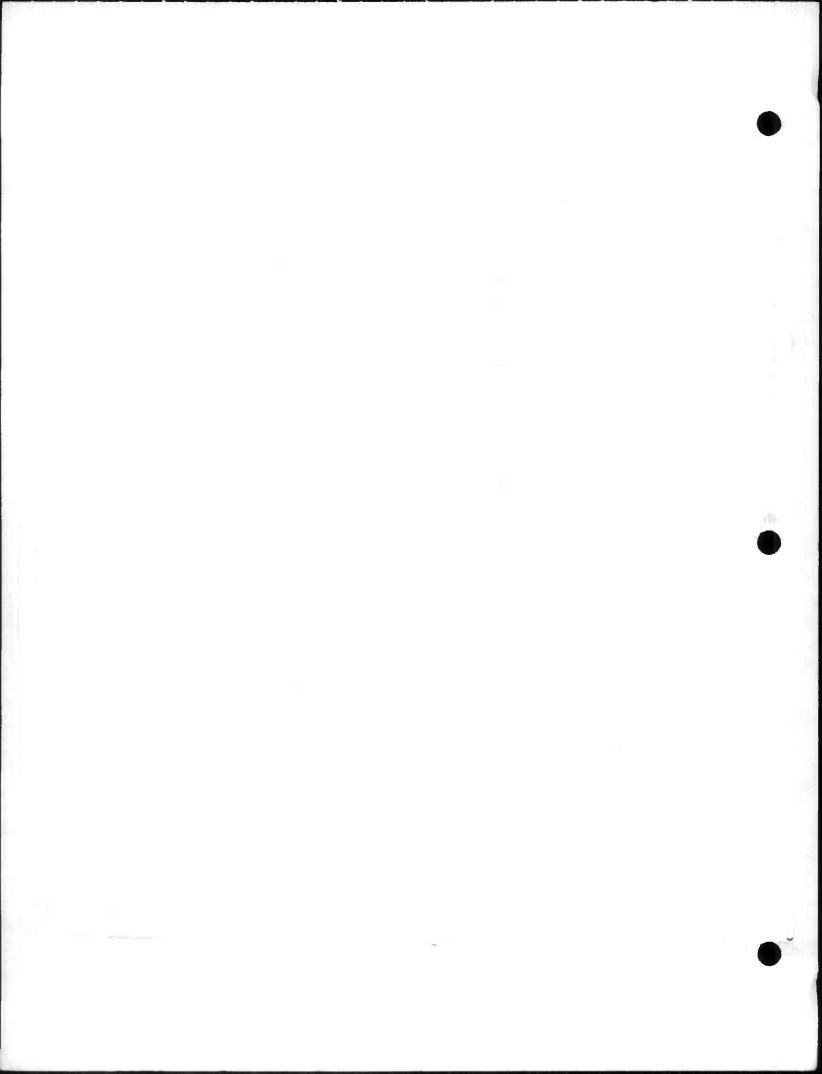
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an interpretary. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. S BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

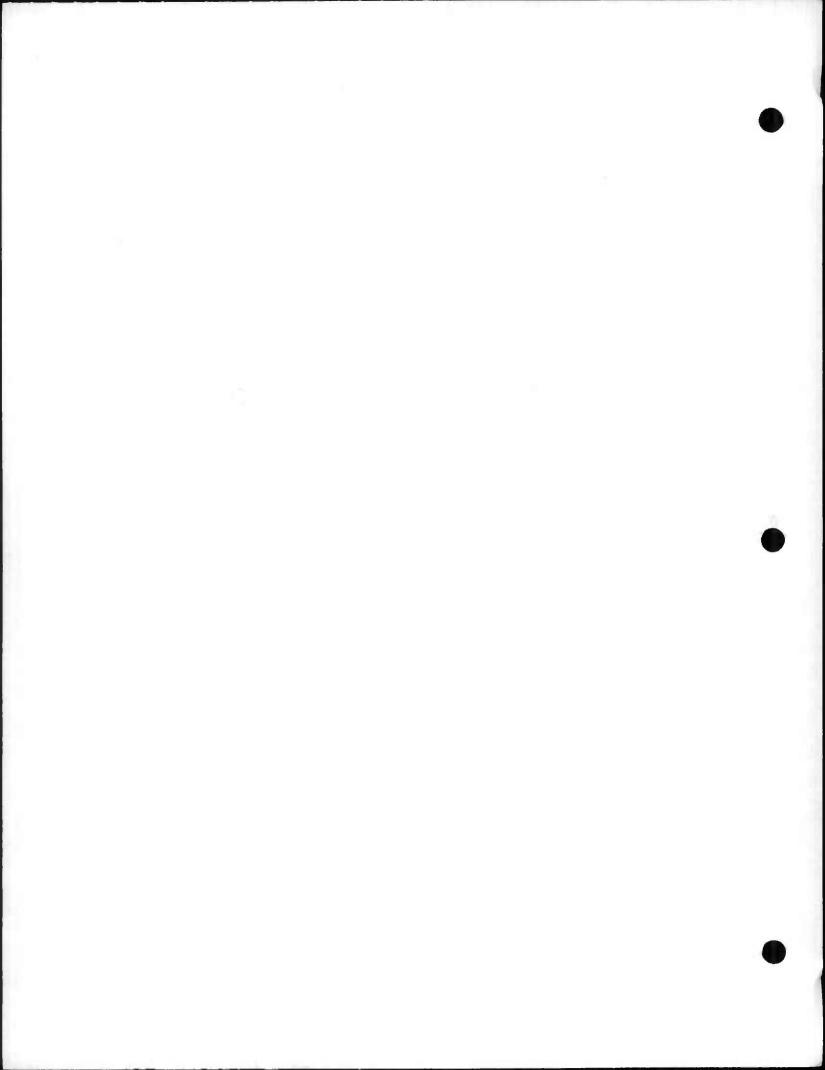
1 - STATE REGISTRAR

_	TIEGIOTTIAIT				OLIT		AIL	L DEW	110		HEG. NO.			
	1. DECEDENT'S NAME (First ROBERT	, Middle, Lest) MCF	AT.T.	MEADE	R					2. DATE OF MAY	DEATH 9	W 1	955	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In)		*****								7:41 a _M
	577-28-513		1 M 2 F				UNDER 1 YEA		MIN.	7. DATE OF	BIRTH 27.7 1	924	Count Wash	HPLACE (State or Foreign my)
	9e. FACILITY NAME (If not in		reet and number)			96	b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE							
5	Washington Adventist Hospital							a Park					tgom	
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY													
빌		Dred mo.			10		OWN OR LO	CATION						10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER		Georges			Ade.	lphi					r .		1 K YES 2 NO
FUNERAL	2709 Higbee							101. ZIP COD	Æ 783			12.00	ISA	WHAT COUNTRY?
3	11. MARITAL STATUS	Road	12. WAS DECEDEN	T EVER IN U.	.S. ARMED)	13. WAS I			NIC ORIGIN? (Specify Vee			E — American Indian,
	1 Never Married 2 🗵		FORCES? 1	X YES	2 NO		If yes,	specify Cub	nn, Mexica	in, Puerto Rici	an, etc.)	01 140-	Black	k, White, atc.
BÝ	3 Widowed 4 Divo	orced	IF YES, GIVE W	II				ES I Z NO	Specin	y.			Spec	White
		EDENT'S EDUC y highest grade		16	(Give k	and of work	JAL OCCUP	ATION most of worki	ing	16b. Ki	ND OF BUS	INESS/IN	DUSTRY	
١٣	Elementary/Secondary (0	0-12)	College (1-4 or 5 d			NOT use re	_{tirod.)} Mecha	nic		F1	.evat	or D	nair	_
COMPLETED	17. FATHER'S NAME (First, M	licicile (ast)			ileva	LOI	песпа		WED'S NA	ME (First, Mide			epali	
	Harry Louis		r							lberta		Surname)		
BE	19a. INFORMANT'S NAME (19b. M/	AILING AD	DRESS (Stre			Route Number,		n, State, Zi	p Code)	
임	Elizabeth M	leader			270	9 Hig	gbee	Road,	Adel	Lphi,	Mary1	land	207	83
	20a. METHOO OF DISPOSIT	ION on 3 🗆 Reme	oval from State	20b. PL	LACE AND	DATEOF D	ISPOSITION	(Name of		OATE			City or To	
	4 Donation 5 Other	(Specify)		For	t Li	ncol		mator	_					Maryland
	21. SIGNATURE OF FUNERA	L SERVICE LIE	H				1180	O NAT	SS OF FA	ourvHin pshire	es-R:	inal	di Fu	ineral Home
0	Froher	4.	Jan Ly	1			Silv	er Sp	ring	, Mary	land	20	0904	
	23. PART I. Enter the d shock, or h	eert fallure.	omplications the	t caused the	he death.	Do not	enter the	mode of dy	ing, suc	h as cardia	c or respi	ratory ar	reat,	Approximata Interval Between
ı	iMMEDIATE CAUSE (Fir disease or condition	nal	0.1	C	4.0.1	2 1 4					Onset and Death			
	reaulting in deeth)	→	PN DUE TO	EUN	CON	11/4								4 DAYS
_		_		UTR			IA							LUISEV
2	Sequentially list condit		OUE TO	(OR AS A CO	DNSEOUEN	NCE OF):								
CERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or Inju	ING	ME.	TAS	TAT	70	L	NB	CF	ARCII	NON	HA		ZMUNTHS
	that initiated events reaulting in death) LAS		DUE TO	(OR AS A CO	DNSEOUEN	NCE OF):								
5			f											
	PART II. Other aignifica	nt condition	s contributing to	death but	not reau	iting in t	he underly	Ing cause	given in	Part I. 24	la. WAS AN		24b	WERE AUTOPSY FINDINGS
EDICAL	THROMB	0 CYT	OPENII	4	CE	LLL	1417	15,		_ 1	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M				,				,						1 YES 2 NO
	DID TOBACCO U		RIBUTE TO CA						CERTAI	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28.	PLACE OF	-	Check only o	ne)						
1×S	1 YES 2 NO		1) Inpatient 2			DOA 4 [Nursing H		anidence	6 Cher (S				
	1 Natural 5	Pending	28a. DATE OF (Month, D.		26	Ib. TIME OF		INJURY AT WORK? YES 2	□ NO	26d. DEŞCR	IBE HOW II	JURY OC	CURED	
B	a - a	Investigation	28e. PLACE O	F INJURY —	At home.	form, stree			J NO	284 LOCATI	ON /Street o	ad Numba	e or Dural S	Route Number,
		Could not be determined	building,	atc. (Specify)			.,,				lown, State)	no mone	or nover r	voore reamber,
۳	29a. CERTIFIER 1 CERT	TIFYING PHYSIC	CIAN: To the best of	my knowlede	ne, death o	necurred at	the time of	eta and place	and due	to the caused	a) and man		4.4	
COMPLET														i) and menner se stated.
Ŭ	- 0.1	OF CERTIFIER	A						ENSE NUA					(Month, Dey, Year)
0 8		Me	IN ISN	Mi	5			11-	3156			D/V	IAY	10,1995
ř	CHARLES	M B	COMPLETED CAUSE	MP	(ITEM 27)	17/pa, Prin	1 6	cken	1000	DR	IVE	,51	WE	RSPRING!
	31. DATE FILEO (Month, Day,		#2. REGISTRA		JRE		_		-					
	MAY 11	1995	Julia alle	olsonRa	Mall									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neutited at one.
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, .	mended # 18 FOR 1 - STATE REGISTRAR	5/11/9	5 MR	T	Mor	ntgo	m	ery	Con	35,	15997
	1 - STATE REGISTRAR	SIAIE UF I	MAKYLANU / L CEI	RTIF	IMENT OF I	DE AT	AND I	MENTAL HYGI	ENE	/	
	1. DEGEDENT S TIAME (First, MIOUR, Last)							2. DATE OF OFATE		3	. TIME OF DEATH
	PAULINE E. McCA	RTHY						May 9, 1	995	YEAR	7:15 A.m
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last t	birthday)	IF UNDER 1 YEAR	IF UNDER 2		7 OATE OF BIRTH	A. L.	8. BIRTNPL Country)	ACE (State or Foreign
	577-26-0102	1 🗆 M 2 💢 F	91	YRS.	MONTHS DAYS	HOURS	MIN.	May 24,	1903	Virg	inia
-	9e. FACILITY NAME (If not institution, give				9b. CITY, TOWN			ATN	9c. COU	INTY OF DEA	тн
1 2	Friends Nursing Home Sandy Spring Montgomery									ry	
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. I									Od. INSIDE CITY	
19	Marviand I Montgomory I Dockytilo									LIMITS? YES 2 [X] NO	
FUNERAL	10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?										
l ä	13727 Lionel Land	9				20853			Uni	ited S	tates
5	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. ARMI		13. WAS DEC	ENDENT OF	NISPAN	IC ORIGIN? (Specify	Yee or No-	14. RACE -	- American Indian, White, alc.
B	3 X Widowed 4 Divorced	IF YES, GIVE W			1 TES	2 X NO	Specify	·		Specify:	
	15. DECEDENT'S EDU	ICATION	16a, DECE	EDENT'S	USUAL OCCUPATION	ON		16b. KIND OF	DI ICINIEGO /INI	Whi	te
ET	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 -	(G/ve	kind of w	ork done during mo	est of working		TOOL KIND OF	503111E3371NI	DOSTAT	
AP I	12	5000		e C1	erk			U.S. T	reasur	y Dep	artment
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		-			18. MOTHE	ER'S NAI	ME (First, Middle, Mai			
BE (Charles M. Pidge	eon						-DeVol	Duv.	911	
0	19a. INFORMANT'S NAME (Type/Print)							loute Number, City or			
	Charles J. McCar	rtny					, Ro	ckville,			20853
	20e, METNOD OF DISPOSITION 1 ABurlel 2 Cremellon 3 Rem	oval from State	20b. PLACE AN cometery, crema	ID DATEO	F DISPOSITION (Na	ime of		DATE 20c.	LOCATION -	City or Town	, Slata
	4 Donalion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	_ Ariing	ton	Nationa 22. NAME AF	I Cem	e te	ry 5/16 A	rlingto	n, Vir	ginia
	Da V	1 /			Rapp F	Funera	al S	ervices.	P.A.		
	Callen F	1. / Cay	pp		933 G	ist Av	/enu	e, Silve	r Spri	ng, M	D 20910
	23. PART I. Enter the diseases, or shock, or heart fallure.	complications the List only one ceu	t caused the deat se on each line.	th. Do n	ot enter the mo	de of dying	g, such	ss cardiac or re	apiratory an	reat,	Approximata Interval Between
	iMMEDIATE CAUSE (Finel disease or condition	P									Onset and Death
	resulting in death)	8. Inch	OR AS A CONSEQUE								24hrs
		DUE TO		ENCE OF)·						2017113
z	_	Cere	brnau [ENCE OF	ical ent						
rion	Sequentially list conditions, if any, leading to immediate	b. Cere	OR AS A CONSEQUE	ar Ac	ccdent						2yrs
ICATION	If any, leading to immediate cause. Enter UNDERLYING	b. Cere	brnaula	ar Ac	ccdent						
TIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. QVE TO	brnaula	ENCE OF	iccd ent						
CERTIFICATION	If any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. Ceve	OR AS A CONSEQUE	ENCE OF	iccd ent						
U U	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO c. DUE TO d	OR AS A CONSEQUI	ENCE OF	iccdent	g ceuse giv	ven in l		AN AUTOPSY	24b, W	
U U	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. Q V e DUE TO c. DUE TO d. T	OR AS A CONSEQUI	ENCE OF	the underlying	g couse giv	ven in l	PERI	ORMED?	AM CC	2 4 7 5 ERE AUTOPSY FINDINGS RALABLE PRIOR TO ROMPLETION OF CAUSE
U U	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. Q V e DUE TO c. DUE TO d. T	OR AS A CONSEQUI	ENCE OF	the underlying	g ceuse giv	ven in l	PERI		CC Of	2 4 7 5 ERE AUTOPSY FINDINGS RALABLE PRIOR TO MPLETION OF CAUSE DEATH?
W W	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition EFDING GASTOS	DUE TO DUE TO d. acontributing to	OR AS A CONSEQUI	ENCE OF	the underlying			1 YES	ORMED?	CC Of	2 4 7 5 ERE AUTOPSY FINDINGS RALABLE PRIOR TO ROMPLETION OF CAUSE
W W	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition TETDING GASTOS Demonta	DUE TO DUE TO DUE TO RIBUTE TO CA	OR AS A CONSEQUI	H YES	the underlying			1 YES	ORMED?	CC Of	2 4 7 5 ERE AUTOPSY FINDINGS RALABLE PRIOR TO MPLETION OF CAUSE DEATH?
W W	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition FETDING GASTOS DIE MATIG DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO	OR AS A CONSEQUI	ENCE OF	the underlying Forch o N S NO C N (Check only one) OTHER:	UNCE	RTAIN	1 YES	ORMED?	CC Of	2 4 7 5 ERE AUTOPSY FINDINGS RALABLE PRIOR TO MPLETION OF CAUSE DEATH?
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BY PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition ECO ING GASTOS DIE MATIGA DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PNYS	DUE TO DUE TO DUE TO DUE TO DUE TO RIBUTE TO CA HOSPITAL: 1 Inpatient 2 26e. DATE OF (Month, Delliding, Delli	(OR AS A CONSEQUION (OR AS	H YESOF DEATH	the underlying FYCLO A S NO C N (Check only one) OTHER: A Nursing Hom COF 286. NAJ HOW M 1 N Treet, factory, office d at the lime, date	UNCE • 5 Reski	RTAIN dence	PERI 1 YES 3 Other (Specify) 28d. DESCRIBE HO' 28f. LOCATION (Street, Street,	ORMED? 2 X NO V INJURY Oci st and Number te)	CURED CORED	2 4 7 5 ERE AUTOPSY FINDINGS BALABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO
PHYSICIAN: MEDICAL CE	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO A BE CONTRIBUTE TO CA HOSPITAL: Inpettent 2 26e. PLACE OF building. CIAN: To the best of an	(OR AS A CONSEQUION (OR AS	H YESOF DEATH	the underlying FYCLO A S NO C N (Check only one) OTHER: A Nursing Hom COF 286. NAJ HOW M 1 N Treet, factory, office d at the lime, date	UNCE • 5 Reski	RTAIN dence	PERI 1 YES 3 Other (Specify) 28d. DESCRIBE HO' 28f. LOCATION (Street, Street,	ORMED? 2 X NO V INJURY Oci st and Number te)	CURED CORED	2 4 7 5 ERE AUTOPSY FINDINGS BALABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO
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TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h

PHYSICIAN: MEDICAL

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1 YES 2 X NO

6 Could not be

27. MANNER OF DEATH

1 X Netural

2 Accident

3 Suicide

4 Nomicide

Pages 1, 2, 3 should

permit.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ottis 1995 YEAR McCarty May 8, 11:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign June 20, 1906 454-07-9800 DAYS 1 [X M 2] F 88 HOURS Texas 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Kensington Gardens Nursing Home Kensington Montgomery RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Montgomery Bethesda 1 YES 2 XNO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9803 Parkwood Drive 20814 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, apecify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 X Widowed 4 Divorced Specify White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Welder Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Pear1 Alexander Cornelius McCarty Daisy Ricketson 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zana R. Miller Same as #10 20a. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State
4 Denation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State OATE Sunset View Cemetery 5-11 Berkeley, California 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rapp Funeral Services, P.A. M00827 933 Gist Ave, Silver Spring, MD 20910 23. PAST I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. Liet only one cause on each line. intervai Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Alzheimer's Disease 5 Yr's resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST

PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. Renal Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 XT NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH? 1 YES 2 (X) NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL

28s. DATE OF INJURY

26. PLACE OF DEATH (Check only one) HOSPITAL:

Inpetient 2 ER/Outpetient 3 DOA

28b. TIME OF INJURY

OTHER:
4 X Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT WORK? 28d. OEȘCRIBE NOW INJURY OCCURED

D 22235

1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

1 XCERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the bees of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

M.D.

286. SHEMAPTIME AND TITLE OF CENTIENS 29d. DATE SIGNEO (Month, Day, Year) 29c. LICENSE NUMBER Wesley

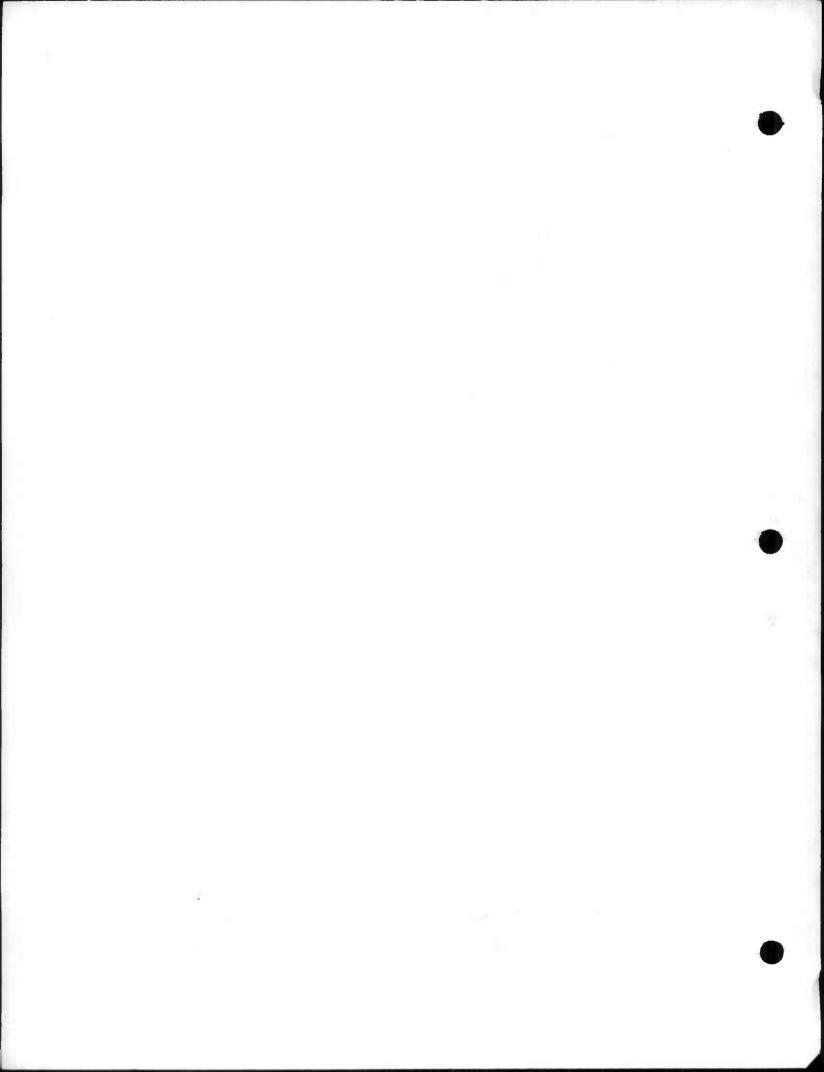
nason 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Wesley B. Mason, M.D. 10810 Connecticut Ave, Kensington, MD

31. DATE FILED (Month, Day: Year) 12. REDISTRAR'S SIGNATURE MAY 11 1995

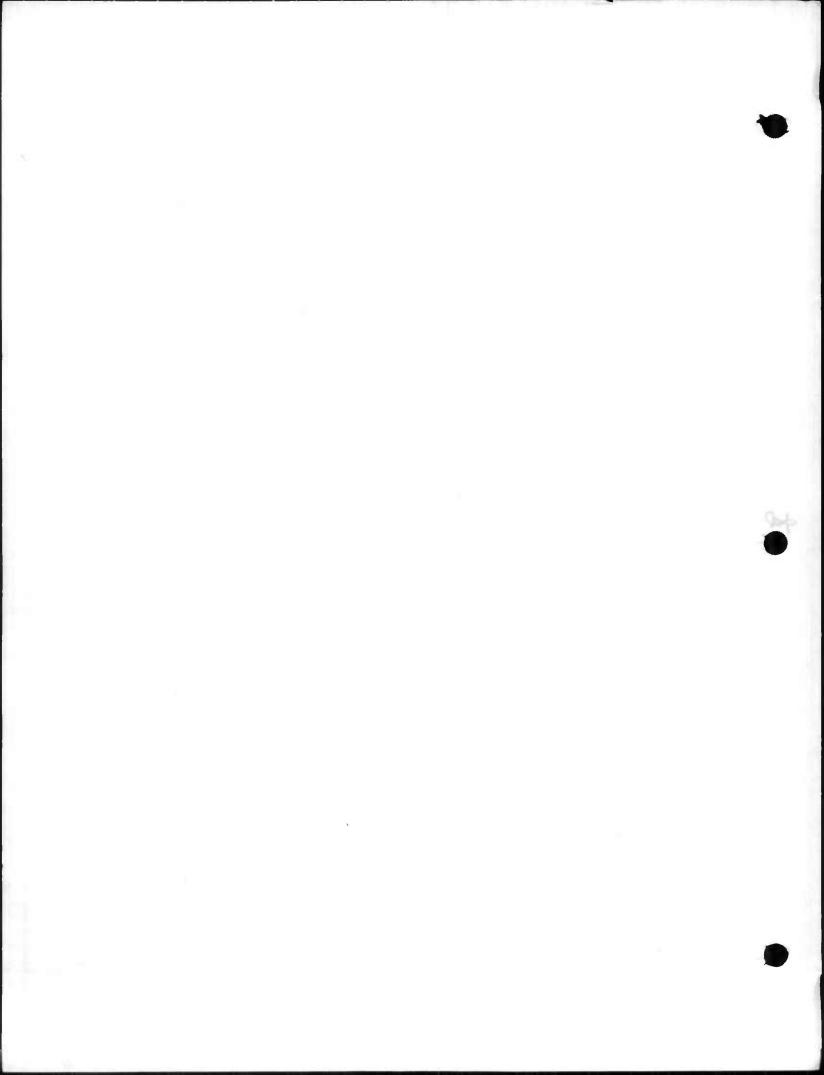
Devoler Revolate

May 9, 1995



IAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Za nours after death. Page 6 may be retained by the hospital or attending physician.	98:	ingo wight it follows and beautiful the page to be reading any mention mygleric prior to donate, definable, or introduced to them 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: Aft	IMPORTANT: If Item 28 is n

	FOR STATE REGISTRAR	STATE OF I	MARYLAND C	/ DEPAR	RTMENT OF I	HEALTH	AND I	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)			<u> </u>				2. DATE C	F DEATH			3. TIME OF DEATH
	Hoke S. Moody, Jr.						May 14 19			95	11:00 Pm	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE O (Month,	Day, Year)		8. BIPTI Count	IPLACE (State or Foreign
	424-40-5996		63	YRS.				Feb	. 17	1932		abama
ac	9a. FACILITY NAME (If not institution, give s				96. CITY, TOWN			HTA		9c. COU	NTY OF D	EATH
2	3936 Chesterfield	Avenue			Bal	timor	^e					
DIRECTOR	10a. STATE 10b. COUNTY	,		10c. CIT	CITY, TOWN OR LOCATION 10d. INSIDE						10d. INSIDE CITY	
		arroll		Westminster							1 TES 2 NO	
RAL	2311 Hampstoad Mo	vice Dea	d	0.4.4.55							WHAT COUNTRY?	
FUNERAL	2311 Hampstead Mexico Road 21157 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGINAL SPACE OF NO.							US				
	1 Never Married 2 Married	FORCES? 1	YES 2 X	NO	13. WAS DEC	CENDENT Cubi	of Hispan an, Mexica	NC ORIGIN? n, Puerlo Ri /:	(Specify Ye can, etc.)	s or No—	Blaci	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divorced	IF 123, GIVE 1	WH OH DATES		1 U YES	2 5 M MO	Specify	y:		- 4	Spec	"White
9	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. D	ECEDENT'S	USUAL OCCUPATI work done during m se retired.)	ON ost of world	ina	16b. I	UND OF BU	ISINESS/INI	DUSTRY	
E	Elementary/Secondary (0-12)	College (1-4 or 5	+) h							D 2 - L		
COMPLET	17. FATHER'S NAME (First, Middle, Last)			nanc	licapped					Disab	rea	
	Hoke S. Moody, Sr						OUIS	ME (First, Mi	ddle, Maider	McKi	rnrnio	
BE	19s. INFORMANT'S NAME (Type/Print)	•	1	95. MARLING	ADDRESS (Street				e Clay or Tox			
2	Mildred M. Sturge	on			Tarpon							1 34685
	20a. METHOD OF DISPOSITION 1 Å Burlel 2 ☐ Cremation 3 ☐ Rema	0.014.001.46.00	20b. PLACE	E AND DATE	OF DISPOSITION (N	ame of				OCATION —		
1 1	4 Donation 5 Other (Specify)		Doth	nan Ci	ty Ceme	tery		5-19	Do	than,	AL	
	21. SIGNATURE OF FUNERAL SERVICE NO	ENSEE	/ /		22. NAME A	ings	SS OF FA	eral				
	Seld. S	~~	0/.		3111	Mour	ntain	Road	l, Pa:	saden	a. M	D 21122
	23. PART I. Enter the tiseases, or c shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	omplications the	t ceused the duse on each lin	leath. Do i	not enter the mo	ode of dy	ring, suci	h as cardi	c or resp	oiratory an	rest,	Approximata Interval Between Onset and Death
	resulting in death)	a. U QV	18 AS A CONS	EDITENCE O	MOOR							years
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL C	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in F							PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. P	LACE OF E	EATH (Ch	eck only one)				
YS	1 TYES 2 NO	1 Inpetient 2		1	4 - Nursing Hon		esidence	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH 1 Matural 5 Pending	26a. DATE OF (Month, C		28b. TIM	JURY WO	JURY AT	¬	28d, DESC	RIBE HOW	INJURY OC	CURED	
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE C	F INJURY — At h	ome form	street, factory, offic	YES 2 [_ NO	201 1 000	10N (0)			
윤	4 Homicide 6 Could not be determined	building,	etc. (Specify)	ovino, rating	octory, otto	.•			Town, State		OF HURBI I	Route Number,
9	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	MAN: To the heat of	one for existe day of		Now works	BATTO				J		
COMPLET	(Check only one) 2 MEDICAL EXAMINE) and manner as stated
	296. SIGNATURE AND TITLE OF CENTIFIER					-	ENSE NUN		_ ,,			
BE	ARONOO W	2				7	36	117		DAT	G 114	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO						00	116	•		1/10	
	D. Alexander Roch	a, MD, 4	500 Bla	ckroc		Hamp	stea	d, MD	2107	74		
	31. DATE FILED (Month, Day, Your) MAY 2 5 1995	12. PAGISTA	R'S SIN ATURE	!					L.P.			



DIVISION OF VITAL RECORDS, P.O. BOX 68760 & BALTIMORE, MARYLAND 21215-0020	L. OR ATTENOING PHYSICIAN: The law requires that the death certificate be executed within Z4 nours after death. Page 6 may be retained by the hospital or attending physicia	LOIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tr
RDS, P.O. BOX 68760	at the death certificate be executed within 24 f	by the attending physician and completely fille
DIVISION OF VITAL RECO	L OR ATTENDING PHYSICIAN: The law requires that	OIRECTUR: After this certificate has been signed

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RIMENT OF H	HEALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) HLA MAUNG					MAY 13,	MY 1995 YEAR	3. TIME OF DEATH 19:55		
	4. SOCIAL SECURITY NUMBER 213-29-4838 9a. FACILITY NAME (If not institution, give a	1½ M 2 □ F 8]	In yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE		1914 Ran	THPLACE (State or Foreign stry) GOON Burma		
TOR	St. Agnes Hospita			Balti			96. COUNTY OF Balti			
DIRECTOR	Maryland Hot	ward		Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 4563 Kings Cup Co	ourt		10	21042	2	10g. CITIZEN OF	WHAT COUNTRY?		
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	U.S. ARMED 2 NO ATES	If yes, sp		IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	fee or No— 14. RACE — American India: Black, White, etc. Specily: Burmese				
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	16e. DECEDENT'S (Give kind of life. Do NOT us Engil		ON ast of working		16b. KIND OF BUSINESS/INDUSTRY Construction				
E COMPL	17. FATHER'S NAME (First, Middle, Last) Ba Tun	4	шды	ICCI	16. MOTHER'S NAME AYE	ME (First, Middle, Meiden Khin				
TO B	190. INFORMANT'S NAME (Type/Print) Khin Maung U.				and Number or Rural F	Houte Number, City or Tow Ellicott		21042		
	20a. METHOD OF DISPOSITION 1	oval from State		of disposition (Na ther place) Cremato	ry Ma	ay 17	Cation - city or 1 Laurel,			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043									
	23. PART I. Enter the decases, of shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	INTRACKANA	ich ilne. N HEA/	MURRHAGE		n an cerdinc or reap	iratory arreat,	Approximate interval Between Onset and Death		
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
ICAL C	PART II. Other aignificent condition	a contributing to death b	ut not resulting	in the underlying	g cause given in	PERFO	RMED	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
IAN: MEDICA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNEW OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outp		OTHER: 4 Nursing Hom	e 5 Residence					
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 .	PRK? YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED				
ETED	3 Suicide S Could not be determined 29e. PLACE OF INJURY — At home, ferm, street, tectory, office City or Town, State) 28t. LOCATION (Street and Number or Rural Route Number of Rural Route Number or							noute Namber,		
COMPL	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowler: R: On the basis of examination						e) end manner ee stated.		
TO BE	296. SIGNATURE AND TITLE OF CERTIFIES	dilok			2065	BER	≥ 5-13-	(Month, Day, Year)		
-	30. NAME AND ADDRESS OF PERSON WH	IDELOX	ST		HOSPITAL	P				
	31. DATE FILED (Month, Day, Year) MAY 1 6 1995	Julia Stutles	Revolute							